Exploring the perceptions of medical officers and registered nurses about family presence during cardiopulmonary resuscitation

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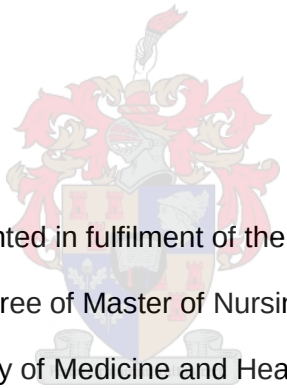

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DECLARATION

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ABSTRACT

Background: In emergency units, cardiopulmonary resuscitation (CPR) occurs daily as a life- saving intervention for crittically ill patients. Traditionally, families are told to wait outside when CPR commences. Family presence during CPR is when one or more family members witness all interventions performed and who provides physical or visual contact to the patient during the resuscitation event. Ever since family members requested to be present during CPR in 1980's at Foote Memorial Hospital in Michigane America, to allow this practice has been a controversial concept amongst healthcare providers. In a secondary provincial hospital in the Western Cape of South Africa, family members are mostly not allowed, or are seldom offered the opportunity to be present during a resuscitative event as no standardised practice or protocol is in place. Some medical and nursing personnel conventiently do not allow family to witness the CPR on their family members, which create confusion amongst families, navigating away from facilitating family-centred care.

Methods: A qualitative approach with an exploratory-descriptive design was utilised. Data was collected by a fieldworke using in-depth individual interviews with healthcare providers. A self-developed, semi-structured interview guide with open-ended questions and probes were used. A final total of 10 participants took part in the study after giving informed concent. Trustworthiness was maintained throughout the study. Member checking took place during the interviews to summarise the participants' information as well as a follow-up meeting. Transcribing was done by the primary researcher. The data was analysed by the primary researcher who followed the content analysis process.

Results: Five main themes surfaced from this analysis: Information communication; benefits and challenges of family presence; the family's choices and reactions, types of CPR cases and the health professional's professional's interactions and skills during the CPR process. The findings of the research study illustrated the importance of communication to the family and to provide them with accurate information. The choices to be present or not to be present as well emotional reactions of the family have an impact on the decision to allow family to be present or not. The types of CPR cases and prognosis of the patient influences the decision

to allow the family in the resuscitation room and the different reactions families can experience, have an impact on the decision to allow family to be present or not. The professional skills and interactions of the healthcare team are an important aspect that influences the decision to allow family to be present.

Conclusion: The perceptions of medical officers and registerd nurses about family presence during cardiopulmonary resuscitation at a secondary hospital provide the emergency department with a deeper understanding and knowledge around family presence practices.

Key words: Family, cardiopulmonary resuscitation, medical officers, nurses

OPSOMMING

Agtergrond: Kardiopulmonale resussitasie (KPR) vind daagliks plaas as ‘n lewens-rededinde aksie in nood eenhede. Gewoonlik word families gevra om na buite te gaan terwyl KPR aanvangs neem. Familie teenwoordigheid gedurende KPR is wanneer een of meer familielede toekyk hoe die intervensies uitgevoer word en ook fisiese of visuele kontak verleen aan die pasient tydens ‘n resussitasie aangeleentheid. Sedert die families versoek het om betrokke te wees by KPR by die Foote Memorial Hospitaal in Mechigin Amerika, is hierdie praktyk kontroversieel van die gesonheidswerker perspektief. By die sekodere provinsiale hospitaal in die Weskaap provinsie in Suid Afrika, word familielede nie toegelaat nie of word selde die geleentheid gebied om deel te wees by KPR aangesien daar nog nie ‘n standaard praktyk of protokol inwerking is nie. Vir gerieflikheidshalwe is daar sommige mediese en verpleegpersonneel wat geen familie toe laat tydens KPR van ‘n familielid nie, wat dus wrywing tuusen families kan veroorsaak, weg van die fasilitering van gesinsgesentreerde versorging

Metode:’n Kwalitatiewe benadering met ‘n eksploratiewe- beskrywende ontwerp was gebruik. Data kolleksie was gedoen deur ‘n veldwerker wie indiepte individuele onderhoude met gesondheidswerkers geloots het. ‘n Self-ontwikkelde semi-gestruktureerde inderhouds gids met oop- as ook ondersoekende vrae was gebruik. ‘n Finale totaal van 10 deelnemers was deel van die studie nadat ingeligte toestemming verleen was. Betroubaarheid was deurentyd gehandhaaf. deelnemer kontrolering het tydens die onderhoude plaasgevind asook tydens opvolg onderhoude om die informasie van deelnemers op te som. Transkribering en inhoudsanalise was deur die primere navorser gedoen.

Resultate: Vyf temas is verkry vanuit hierdie analise: Informasie kommunikasie; voordele en uitdagings van familieteenwoordigheid; familie keuses en reaksies; die tipe KPR geval asook die professionele interaksies en vaardighede tydens die KPR proses. Die bevindinge van die navorsingsstudie illustreer die belangrikheid van kommunikasie en om die familie van korrekte inligting te voorsien. Die keuses van die familie om teenwoordig te wees of nie teewordig te wees nie asook die emosionele reaksies van die families het ‘n impak op die besluitneming om familie

toe te laat of nie. Die tipes van KPR gevalle en prognoses van die pasient beinvloed ook die besluit om familie toe te laat in die resussitasie kamer. Die voordele en uitdagings wat familieteenwoordigheid op kliniese praktyk kan hê, is uitgewys. Die professionele vaardighede en die interaksies van die gesondheidspan is belangrike aspekte wat die besluit om families toe te laat om teenwoordig te wees, beinvloed.

Slotsom: Die persepsies van mediese beamptes en geregistreerde verpleegkundiges oor die teenwoordigheid van familie gedurende kardiopulmonale resussitasie by ‘n sekondêre hospitaal, het die noodeenheid van dieper insig en kennis voorsien rondom familieteenwoordigheidspraktyke.

Sleutelwoorde: Familie, kardiopulmonale resussitasie, mediese beamptes, professionele verpleegsters

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ABBREVIATIONS

ALS	Advanced Life Support
BLS	Basic Life Support
CPR	Cardiopulmonary Resuscitation
CEO	Chief Executive Officer
DNR	Do-not-resuscitate
EC	Emergency Centre
FPDR	Family presence during resuscitation
FWR	Family-witnessed resuscitation
MO	Medical Officer
RN	Registered Nurses

CHAPTER 1

FOUNDATION OF THE STUDY

1.1 INTRODUCTION

In emergency units, cardiopulmonary resuscitation (CPR) occurs daily as a life- saving intervention for critically ill patients. Traditionally, families are told to wait outside when CPR commences (Gordon, Kramer, Couper & Brysiewicz, 2011: 765). Family presence during CPR can be defined as one or more family members who witness all interventions performed and who provides physical or visual contact to the patient during the resuscitation event (Fernandes, Carneiro, Geocze, Santos, Guizillini & Moreira, 2014: 86). Family presence during CPR dates back to the 1980's (Brasel, Entwistle & Sade, 2016: 1438) in the Foote Memorial Hospital in Michigan, America, where family members requested to be present during CPR of their loved ones, were allowed to do so. Ever since this incident, to allow this practice has been a controversial concept amongst healthcare providers.

The researcher, working at a secondary provincial hospital in the Boland region of the Western Cape, has observed that while the medical and nursing personnel focus on attempting to resuscitate the person, the family is immediately plunged into a crisis precipitated by uncertainty, worry and fear that their loved one may not survive. As a registered emergency nurse, the researcher had further observed that some healthcare providers allow family members to be present, while others do not allow the family such presence. In this particular secondary provincial hospital, family members are mostly not allowed, or are seldom offered the opportunity to be present during a resuscitative event as no standardised practice or protocol is in place. Some medical and nursing personnel conveniently do not allow any family members to witness the CPR on their loved one, which create confusion amongst families. The decision have a negative impact on the relationship between the healthcare professionals and family members, as well as between the family members who are included and those excluded from the resuscitation event. It is with this background that the researcher deemed it necessary to explore the perceptions of the medical officers and nursing professionals about family presence during CPR.

1.2 RATIONALE

Although the practice of family presence during CPR dates back to the 1980's, it is still controversial, despite its benefits (Brasel et al., 2016: 1438) and it is still not a common practice in intensive care units (Power & Reeve, 2018). Despite the contreversy, many professional organizations on the international front support the practice of family presence during CPR, such as the American Heart Association, the European Resuscitation Council, and the Emergency Nurses Association. A study done by Lederman (2016: 5) showed a comparison of findings between two of the world's leading organizations with regard to the practice of having the family present during resuscitation. The comparison showed that the European Resuscitation Council provides a stronger recommendation

and support for the practice to allow the family to be present during resuscitation than the American Heart Association (Lederman, 2016: 5). The American Heart Association had mixed results with regards to this practice.

Therefore, families may feel that they are being treated unfairly and have animosity towards healthcare professionals. Meeting the families' expectations by giving them the option or allowing them to be present during CPR will improve psychological outcomes for the family members (Oczkowski, Mazzetti, Cupido & Fox- Robichaud, 2015: 5) and allow the family the opportunity to say goodbye (Al-Mutair, 2017: 4). However, in a study done in Australia, nurses and physicians indicated that the presence of family members interrupts the CPR process, and therefore is an obstacle to the operations (Hassankhani, Zamanzadeh, Rahmani, Harririan & Porter, 2017: 133). A systematic review about whether the family should be allowed during resuscitation by Abbas Al- Mutair (2017: 1) also indicated that healthcare providers are of the opinion that the practice interfere with the treatment but the author admitted that family presence during resuscitation could have a positive effect on the patient and his/her family.

Various research studies found the practice to be perceived as beneficial from the patient as well as the family's perspectives (Critchell & Marik, 2007: 311). Powers and Candela (2016: 54) in an American study explained that families and patients feel that it is their right to be present. Many family members have stated that it is more than just a privilege to be present during, what will be their last moments, with their loved one. The findings of the same study also stated that 90% of the successfully resuscitated patients wanted their families in the room with them. Furthermore, families whose loved ones had died, and had not been present mentioned, that the opportunity to be part of the resuscitation event should have been provided to them (Powers & Candela, 2016: 55; Fernandes et al., 2014: 60; Critchell & Marik, 2007: 314).

In a South African study (Le Goff, 2012: 15), results showed that critical care nurses had mixed opinions about the practice of family presence during CPR. Some critical care nurses found it rewarding and helpful since it decreases the grieving process and brings closure to the family. Others mentioned that it is traumatic for the family and that the family members may behave in a disruptive way towards the healthcare personnel (Le Goff, 2012: 15).

Family presence during CPR is one of the ways to facilitate family-centred care (Al-Mutair, 2017: 10). Family-centred care can promote partnerships between the family and the healthcare provider in the planning, provision and evaluation of care to their loved one (Almaze & De Beer, 2017: 1). Healthcare providers, especially medical officers and registered nurses, are on the frontline of the CPR process in the emergency units and should be aware of the value of family presence during CPR, despite their different opinions about the matter. With the abovementioned information and the experience of observing this problem in the emergency unit, where the researcher is working, the rationale for engaging in this study is that it would be beneficial for the healthcare provider to

facilitate family-centred care. It would benefit the patient and his/her family as this would provide them insight to understand what emergency care and the CPR process entails.

1.3 PROBLEM STATEMENT

Inconsistent practices by medical officers and registered nurses, regarding family presence during CPR is a problem at a provincial hospital in the Boland region of the Western Cape Province. Some medical officers and nursing professionals allow or propose for the family to be present while CPR is done on their family members. Other medical officers and nursing professionals do not allow or give the family the option to be present during the CPR process. The participant's decisions have a negative effect on the relationship between the healthcare professionals, the different families who are included and those who are excluded from the resuscitation event. Furthermore, not allowing the family to be present during CPR undermines the practice of family-centered care in the emergency unit. Therefore, an investigation is required to explore the perceptions of medical officers and nursing professionals about family presence during CPR.

1.4 RESEARCH QUESTION

What are the perceptions of the medical officers and registered nurses about family presence during CPR in a secondary provincial hospital in the Province of the Western Cape, South Africa?

1.5 RESEARCH AIM

The aim of the study was to explore the perceptions of medical officers and registered nurses about family presence during CPR in a secondary provincial hospital in the province of the Western Cape in South Africa.

1.6 RESEARCH OBJECTIVE

The objective of the study was to explore and describe the perceptions of registered nurses and medical officers about the practice of family presence during CPR.

1.7 RESEARCH METHODOLOGY

For this study, the research methodology will be described and discussed in detail in chapter 3, but a brief outline follows.

1.7.1 Research design

A qualitative approach with an exploratory-descriptive research design was used to explore and describe the perceptions of medical officers and registered nurses about family presence during CPR in this secondary provincial hospital.

1.7.2 Study setting

A natural setting for the participants was selected, which was the emergency centre of a secondary hospital in the Boland region of the Western Cape province in South Africa.

1.7.3 Population and sampling

The research population included the emergency centre's doctors and registered nurses who worked in the emergency centre at the time of data collection. A total population of N=30 healthcare providers was selected, which comprised of 16 registered nurses and 14 emergency medicine doctors.

Purposive sampling was used, which allowed the researcher to select participants who had experience of the phenomenon being studied and who could provide information-rich data (Burns & Grove, 2011: 344). A final total sample size of N=10 participants contributed towards data for the study. The participants were four medical doctors and six registered nurses who were directly involved with CPR.

1.7.3.1 Inclusion criteria

The following inclusion criteria were applied in the sampling process. A participant should:

- Be employed in the emergency centre of the study site.
- Be a registered nurse or medical officer who provides direct care to patients in the emergency centre of the hospital.
- Have at least one year of working experience in an emergency centre.

1.7.3.2 Exclusion criteria

The following exclusion criteria were applied in respect of the study participants:

- People in management positions related to the emergency centre, who did not provide direct nursing or medical care to patients, or who were not involved in emergency situations.

1.7.4 Data collection method

A semi-structured interview guide comprising of open-ended questions was developed by the researcher as per the study objective. In-depth individual interviews were conducted with the assistance from a field worker, after participants voluntarily agreed to be interviewed and gave their written and verbal consent to participate in the study.

1.7.5 Pilot interview

One pilot interview was conducted, of which the data were included in the main study, as the interview and process did not need to be adapted.

1.7.6 Data collection

Data were collected through in-depth individual interviews with participants who met the inclusion criteria and voluntarily indicated their willingness to participate. Data collection was done by a fieldworker using a digital device to capture relevant data. The reason for using a fieldworker was because the primary researcher works as a senior registered nurse in this emergency centre. The fieldworker works in the private health sector, completed both a training course in qualitative interviewing skills and a master's degree in nursing. She conducted 20 individual interviews as part of her own research. In addition, notes were taken to highlight important information conveyed by any participant.

1.7.7 Data analysis

Interview transcripts were organized and fieldnotes analysed (Lincoln & Guba, 1985: 290; Elo & Kygnas, 2008: 109). This was followed by transcribing interviews verbatim and typing fieldnotes. The data were then inductively analysed using content analysis as described by Elo and Kygnas, (2008: 109).

1.8 Trustworthiness

Criteria to ensure trustworthiness in qualitative research, as proposed by Lincoln and Guba (1985), are credibility, transferability, dependability and conformability. The application of these constructs to this study will be explained as follows:

Credibility was ensured through peer review sessions held with the supervisor and the fieldworker on the topic. This assisted with ensuring credibility of the study, where different viewpoints were verified against others. Credibility was further enhanced with member checking. Carlson (2010: 118) holds that member checking is where "participants validate the data they provided during interview". The member checking were done with all participants, including the sharing of transcripts, themes and conclusions.

Transferability was ensured by including a detailed process of the research, as well as a thorough explanation of the findings of this study. The researcher is thus optimistic that the knowledge obtained from the study will provide insight about family presence during resuscitation at the emergency centre of the secondary provincial hospital. However, every situation is unique, and those readers that find the study similar to their situation would be able to relate to it (Shenton, 2004: 70).

Dependability is another criterion proposed by Lincoln and Guba (1985) to establish trustworthiness, and requires review. For this study, data collection and analysis were verified by the supervisor. The researcher and the supervisor listened to the audio recordings, reviewed the transcripts and verified thematic coding during data analysis.

Conformability was ensured through peer review sessions that were held with the supervisor and fieldworker. Member checking was done so that participant's opinions could be clarified in the interviews. Conformability was further enhanced by way of the researcher keeping a reflective journal (Lincoln and Guba: 1985).

1.9 ETHICAL CONSIDERATIONS

Ethical considerations are one of the most important aspects of any research. The research proposal was scrutinised by the ethical committee to ensure that no harm to the participants was anticipated, and permission from the HREC, Ethics Reference number S18/03/047 was given to undertake the reseach study. Once ethical approval was obtained, the research proposal was registered at the National Health Research Database (NHRD). Consent to conduct the study at the secondary provincial hospital were also obtained from the WCHD.

Further approval was obtained from the Chief Executive Officer (CEO) of the secondary hospital where the research study was conducted. Information sessions were held with the CEO and the nursing manager to inform them about the purpose of the study. Information sessions were also held with potential participants working in the emergency centre of the secondary hospital. Those participants who had indicated their willingness to participate, gave informed written and verbal consent to the field worker.

Participants were also informed of their role expected in the interview, which was conversational in nature where the fieldworker asked certain questions and they answered accordingly. No emotional of physical harm were anticipated for the participants. However, a professional counsellor was on standby in case a participant needed assistance.

Interview recordings, transcripts and fieldnotes are locked away in a safe at the researcher's home and will be kept for 5 years after which it will be destroyed.

The research study was guided by the ethical principles of self-determination, confidentiality and anonymity, protection from discomfort and harm, and informed consent, which will be discussed below.

1.9.1 Right to self-determination

Self-determination was ensured where the participant was allowed to make an informed decision about whether to participate in the study without being forced, as described by Burns and Grove

(2011: 110). Furthermore, to follow the verbal explanation, written information on a leaflet regarding the research study was also provided to each participant.

1.9.2 Right to confidentiality and anonymity

To protect the human rights of the participants, the confidentiality, anonymity and privacy of the participants were ensured. Confidentiality was ensured by the management of private data where only the researcher and fielword knows the real identities of the participants, and undertook to mentionen the participamts name in the findings (Burns & Grove, 2011: 525). Therefore the only persons able to link the participants' identities to their responses, were the fieldworker and researcher (Burns & Grove, 2011: 112). Confidentiality was ensured by giving the participants' pseudonyms. For example, an interview with a participant was given a code name,such as Participant no 1. Confidentiality and anonymity were further ensured with the digital recording and interview transcripts.

1.9.3 Right to protection from discomfort and harm

High regard for the well-being and health of the participants was given while they were participating in the study, as they had the right to be protected from harm and discomfort (Pera & Van Tonder, 2016: 331). The fieldworker ensured that the participants were comfortable before the interviews started. A quiet place with comfortable seating and adequate lighting at the emergency centre was used to in which to conduct the interviews. If the participants felt that they wanted to meet at a place more comfortable and convenient for them, it was arranged accordingly. Light refreshments were also available for the participants. Furthermore a telephone was available for the participants if they needed the staff wellness and crisis helpline.

1.9.4 Written informed consent

Detailed and thorough information regarding the study was given to the participants so that they could understand the purpose thereof and could willingly agree to participate before interviews commenced. Consent was obtained verbally as well as in written format from all participants during the information session. The written information leaflets were available in both English and Afrikaans. The fieldworker is fluent in Afrikaans and English and before the interviews she assured the participants that they coulddo the interview in their language of choice. Permission for the digital recording was also obtained from the participants.

1.9.5 Bensmark for ethical research.

The researcher also applied the benchmark for ethical research as described by Ezekiel, Emmanuel, Wendler, Killen and Grady (2004: 932) as stipulated below:

1.9.5.1 Community participation

The researcher showed respect for the cultural differences within the communities in relation to the practice of family presence during resuscitation. In identifying problem that needed further investigation, the findins of this study has the potential to improve trust in the provider-family relationship and patient satisfaction.

1.9.5.2 Social value

The knowledge generated from this research study could lead to improvements in healthcare benefitting for the patient, the families as well as the healthcare provider. In addition the results could also lead to the implementation of a policy as well as training of healthcare providers in allowing family being present during CPR. The policy could describe the circumstances in which a family would be offered the opportunity to be present or not.

1.9.5.3 Scientific validity

The results of this research study could provide the foundation for further research. The findings and recommondations can then be generalized to other healthcare contexts, and improve infrastructure to accommodate the family and their loved one experiencing an emergency.

1.9.5.4 Favorable risk-benefit ratio

The risk-benefit ratio is favourable for the patient, their families as well as for the healthcare provider. In this study, more benefits emerged from the findings when families are offered the opportunity to be present. Healthcare providers were also more considerate towards the needs of the family in crisis.

1.9.5.5 Informed consent

The information that was gathered during this research study was shared in a local language that the participants could understand and special attention was given to inform participants that they could withdraw or refuse to partake in the study at any time.

1.10 OPERATIONAL DEFINITIONS

To improve the understanding of the research study, the meaning of the following terms will be explained as it persains to the study.

Emergency care: According to Mian et al., (2007: 56) it is the care given after an acute incident to a person to sustain life, and could involve cardiopulmonary resuscitation.

Family member: A person who is most important to the patient. This include the patient's family, loved ones and closest friends (Tomlinson, Golden, Mallory & Comer, 2010: 48)

Family member presence during resuscitation: According to Fernandes et al., (2014: 86), it is when two or more family members were present to witness all interventions performed and who provided physical or visual contact to the patient during a CPR event.

Medical Officer: According to the Health Professions Act (no. 56 of 1974), a medical officer is a person who is entitled to practice medicine within the Republic of South Africa and to do physical or mental examinations of persons. A medical officer may diagnose, treat and prescribe or provide medicine and s/he is registered with the Health Professionals Council of South Africa (Republic of South Africa, 1974: 24).

Perceptions: These activities enable medical practitioners and professional nurses to order and interpret the view on family presence during during CPR into meaningful insight. (Pam M. S, 2013)

Registered Nurse: A person who is qualified and competent to practice independent, comprehensive nursing care in a manner and to the level prescribed. A professional nurse is also capable of assuming responsibility and accountability for such practice (Republic of South Africa, 2005).

Resuscitation: A set of emergency procedures that was aimed to revive and stabilise a patient who had no pulse and no respirations (Tomlinson et al., 2010: 47).

1.11 DURATION OF THE STUDY

Ethical approval for this study was obtained from the HREC of Stellenbosch University in March 2018. Permission was granted from the WCDH as well as the CEO of the secondary provincial hospital to conduct the study. The data was collected over a period of two months from 17 August to 21 September 2018. Data analysis was done and the completed thesis submitted in September 2019 for examination.

1.12 CHAPTER OUTLINE

Chapter 1: **Foundation of the study**

This chapter is an introduction and background to the research. It includes the rationale, the aim and objectives, research methodology and study outline.

Chapter 2: **Literature Review**

The literature review presents the literature pertaining to the perceptions of medical and registered nurses about family presence during resuscitation.

Chapter 3: **Research Methodology**

Chapter 3 is an in-depth discussion of the research methodology used in this research study.

Chapter 4: **Data analysis and findings**

Chapter 4 presents the data analysis and the findings from the study.

Chapter 5: **Recommendations**

Chapter 5 presents the results and draws conclusions. This chapter also provides recommendations based on the study's findings and identifies the limitations of the study.

1.13 SIGNIFICANCE OF THE STUDY

This study contributes significantly to the body of knowledge by exploring and describing the perceptions of medical officers and registered nurses about family presence during resuscitation in emergency centres. Therefore, it has the potential to create an environment in which nursing and medical professionals can facilitate family-centred care, which includes the patient and their families in an emergency situation. This concept is important, as it creates an opportunity to contribute to patient satisfaction and quality improvement. The benefits, as explained in chapter 4, can help improve healthcare delivery. Therefore, this study could greatly benefit the patient, their families' as well healthcare providers in making better decisions regarding the patient, with the help of formulation policy about the matter.

1.14 SUMMARY

This chapter gave a brief background and motivation for this study. The purpose was to introduce the topic regarding the perceptions of medical officers and nursing professionals about family presence during resuscitation. This chapter outlined the objectives, the research methodology and ethical considerations of the study. The principles of trustworthiness and the benchmarks of ethical research were explained. The focus of this research study was to explore and describe the perceptions of medical officers and nursing professionals about the practice of family presence during resuscitation at the emergency centre of a secondary hospital in the Western Cape province in, South Africa. In chapter 2, the literature review relating to the study is discussed.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of the literature review is to cultivate a strong knowledge base from which to conduct the research study. Therefore, the literature review aims to explore and describe the international as well as South African context pertaining to perceptions of medical officers and registered nurse about the practice of family presence during resuscitation as found in literature. Legislation on this specific concept was also reviewed and assessed.

2.2 SELECTING AND REVIEWING THE LITERATURE

The literature review process started in February 2017, when the researcher commenced her studies at Stellenbosch University. The library of Stellenbosch University and information services were utilised for sourcing information and articles. The researcher evaluated approximately 100 articles. Relevant studies were obtained from the following databases: PubMed, CINAHL, Google Scholar, and Medline. Keywords included “resuscitation”, “family presence”, “family witness resuscitation”, “medical officers”, and “registered nurses”. Articles using both quantitative and qualitative methodologies were included. The literature on the topic is restricted and the information in the articles were between five to ten years old. Limited published articles were found nationally compared to the multiple international studies that were done.

The findings from the literature review are described under the following headings:

- The background
- Medical professionals’ opinions about cardiopulmonary resuscitation (CPR)
- Nursing professionals’ opinions about CPR
- Opinions about allowing family during resuscitation
- Opinions about not allowing family during resuscitation
- International views of rigts and benefits of family presence
- The South African context
- CPR in relation to health legislation in South Africa.

2.3 BACKGROUND

The concept of family presence during CPR dates back to the 1980's (Brasel et al., 2016: 1438). It started at the Foote Memorial Hospital in Michigan, United States of America. In two separate incidences, different families requested to be present. In the first incident the patient was being resuscitated in the ambulance while, a family member was present. In the second incident, the family member refused to leave the patient and another family member also begged, staff to enter the room (Powers & Candela, 2016: 53). In response to these events, the first survey conducted about the need for this practice, found that 13 of 18 family members would choose to be present during resuscitation if given the option. In addition, 94% of the family members who had chosen to be present, would choose to do it again (Brasel et al., 2016: 1439). Therefore, most of research studies conducted in the United States of America (Twibell, Siela, Riwitis, Neal & Waters, 2017: 321; Zavotsky et al., 2014: 325; Powers, 2017: 125).

Various quantitative and qualitative research studies have revealed that nursing professionals in gereral believe that family presence during resuscitation provides more benefits than risks (Carroll, 2014: 35; Powers, 2017: 135; Twibel et al., 2017: 333; Mian, Warchal, Whitney, Fitzmaurice & Tancredi, 2007: 55). In contrast some nurses and doctors fear that this would be traumatic for the family (Tomlinson et al., 2010: 47; Mian et al., 2007: 54). Studies conducted in Germany (Koberich, Kaltwasser, Rothaug & Albarran, 2010), Poland and Finland (Sak-Dankosky, Andruszkiewicz, Sherwood & Kvist, 2017), Spain (Asencio-Gutierrez & Reguera-Burgos, 2017), Iran (Hassankhani et al., 2017) and Jordan (Bashayreh, Saifan, Batiha & Aburuz, 2013) indicated that registered nurses and medical officers perceived more risks than benefits with family presence during resuscitation. This is in contrast to the studies from the United States of America (Carroll, 2014, Powers, 2017, Davidson, Buenavista, Hobbs & Kracht, 2011; Duran, Oman, Abel, Koziel & Szymanski, 2007; Brasel et al., 2016), South Africa (Le Goff, 2012; Gordon et al., 2011) and Ireland (Madden & Condon, 2007: 439) which indicated where nurses and doctors perceived more benefits than risks related to the practice of family presence during resuscitation.

2.3.1 Medical professionals opinions about cardiopulmonary resuscitation

According to Hoyer, Christensen and Eika (2009: 206) doctors are mostly teamleaders when it comes to resucitation. Therefore, the teamleader is expected to stand back and keep a bird's view on the resuscitation process. The doctors in the role of teamleaders must delegate tasks and responsibilities, organize the team, assess the patient and make decisions about treatment (Hoyer et al., 2009: 244). Ideally, the teamleader should not perform any tasks, unless the urgend need to intervene presents itself, or the size of the resuscitation team is decreased (Hoyer et al., 2009: 244).

The importance of performing good quality CPR is highlighted in the resuscitation guidelines of the American Heart Association (Passali, Pantazapoulos, Dontas, Patsaki, Barouxis, Troupis & Xanthos, 2011: 365). The quality of CPR is related to the knowledge and skills of doctors and other healthcare

professionals. Basic Life Support (BLS) courses are designed to provide the skills to perform CPR, and to use the defibrillator in a safe and effective manner (Passali et al., 2011: 365). The Advanced Life Support (ALS) courses teach advanced resuscitative skills, for example defibrillation with a manual defibrillator, advanced airway management, as well as drug therapy (Passali et al., 2011: 366) Moreover, the medical professionals train in a standardised manner in order to manage cardiac arrest patients, to identify peri-arrest circumstances as well as to provide post-cardiac arrest care, and to work in a team to obtain the best results for the patient. Such training is seen as the golden standard (Passali et al., 2011: 366), with CPR training being mandatory not only for the medical officers, but also for the registered nurses. However, BLS and ALS training can deteriorate rapidly and significantly after training, and it is necessary to initiate refresher courses at regularly so that proficiency in CPR skills can be maintained (Passali et al., 2011: 366).

2.3.2 Nursing professionals' opinions about cardiopulmonary resuscitation

Nursing professionals are seen as firstline healthcare providers and are often present and first responders at a cardiopulmonary arrest by providing initial CPR (Plagisou, Tsironi, Zyga, Moisoglou, Maniandiakis & Prezerakos, 2016: 149). The nursing staff's training has an impact on the effectiveness of CPR as well as the health outcomes of patients. By spending much time alongside patients' bedsides, they are first to attend to in-hospital cardiovascular arrests (Plagisou et al., 2016: 149). Their contribution to healthcare delivery is very important as a resuscitation team member or individually, however, they are often the people who have poor knowledge and skills in terms of the international guidelines and recommendations (Plagisou et al., 2016: 150). Educational programmes in CPR can enhance regiterd nurses' theoretical and practical knowledge decreasing anxiety and increasing their self-confidence (Plagisou et al., 2016: 150). To achieve that, training and development of competence need to happen on an ongoing basis. Given the importance of CPR protect human life, health establishments generally organize (or should organis) regular training programmes to keep nursing health professionals competent (Plagisou et al., 2016: 151).

A study done in a public hospital in Greece, found that nursing professionals have poor theoretical knowledge and skills, not just in emergency centres, but in different clinical departments as well (Plagisou et al., 2016: 151). CPR is recognised as an intra-arrest factor that is associated with a high percentage of survival if dealt with proficiently (Plagisou et al., 2016: 151). Therefore, good theoretical knowledge and skills are prerequisites for nursing professionals to provide effective high-quality CPR. Proper training will enhance the knowledge level of nursing professionals as well as health outcomes through effective care. As such, well-trained nursing professionals can eveluate the unconscious patient and start CPR until the response team arrives, which can improve the patient's chance of survival as well as the hospital outcomes (Plagisou et al., 2016: 151).

According to Plagisou et al. (2016: 152), a study done in Greece found that there is significant correlation between the education level of a person, and the results of a written test. Hence,

registered nurses with additional qualifications achieved higher results than registered nurses with no additional qualification. Generally, education and CPR training are provided to nursing professionals during their undergraduate and postgraduate clinical studies, with regular refresher courses which should keep them up to date with the latets scientifical interventions (Plagisou et al., 2016: 152).

Healthcare establishments must therefore constantly provide for the competence of nursing professionals by good and continous CPR courses if they wish to improve, and ensure that high quality care and safe practices are to be delivered (Plagisou et al., 2016: 152). In Greece, the legislation states that CPR training is compulsory to all healthcare providers (Plagisou et al., 2016: 153). Similarly, in South Africa, the South African Resuscitation Council in collaboration with the American Heart Association stated that it is compulsory for nursing professionals employed in emergency areas to attend CPR courses regularly in order to render high quality and safe care (South African Resuscitation Council, 2015).

2.3.3 Opinions about allowing family during resuscitation

Some studies support allowing the family to be present during resuscitation. According to Hassankhani et al. (2017: 131) family presence can help create trust of the public in the resuscitation team. As the family watches the efforts of the resuscitation team, they would be more reassured and at ease. When families are allowed to be present during the process, they would see the event and their fears and concerns would be decreased. They would also be convinced that the resuscitation team did everything they could and, if death is imminent, there will be no negligence from the resuscitation team's perspective as the family would accept death. Presence of family members during resuscitation would also settle the nerves of the family, reduce the agitation that they might experience and eliminate the families' need to argue with the resuscitation team (Hassankhani et al., 2017: 133). It is also stated that families believe that it is their right to be allowed to be present and being present would help with the grieving process.

However, family presence during resuscitation can also be harmful, especially when it can produce stress and lead to interruption of the actions of the resuscitation team. Dissatisfaction with the process can lead to aggressive argumentative behaviour from the family (Hassankhani et al., 2017: 132).

2.3.4 Opinions about not allowing the family during resuscitation

During the active resuscitation process, both family and patient can experience a major crisis were the patient is fighting for his life, and the family is fearfully awaiting the outcome of the situation (Hassankhani et al., 2017: 133). A variety of opinions exists amongst healthcare providers about the presents of family members, which were influesend by the healthcare provider's previous resuscitation experiences, beliefs, ideas as well as the environment affecting how they will implement (Hassankhani et al., 2017: 131). Hassankhani et al. (2017) found that active resuscitation

in front of the family can have destructive and detrimentel effects for the resuscitation team. These effects come into play where families become so emotional that they would not allow the resuscitation team to continue with the resuscitation, which results in cessation of the resuscitation (Hassankhani et al., 2017: 131). Participants also stated that they lost focus in the presence of the patients' family members, and mentioned that it affected their confidence levels and increased their stress levels.

2.4 INTERNATIONAL VIEWS ON FAMILY PRESENCE DURING RESUSCITATION

This concept was thought to be impossible in healthcare practice, but various international research studies have since been undertaken following the mentioned incident at Foote hospital. In addition, various professional organizations, especially the Emergency Nursing Association in 2005, proposed position statements to offer support of the practice to allow the family member to be present during resuscitation, (Carroll, 2014: 35). This was followed by support from the American Heart Association, the European Resuscitation Council, American Association of Critical Care Nurses, and the College of Critical Care Medicine (Carroll, 2014: 35). They exerted significant influences on facility standards and on patient management, and therefore the acceptance of this practice considered as a gold standard (Laskowski-Jones, 2007: 45).

Furthermore, Lederman (2016: 5) compared the American Heart Association and the European Resuscitation Council's stances towards the presence of family during resuscitation during 2000 to 2015, which illustrated that the European Resuscitation Council provided the stronger recommendation for allowing the family to be present during resuscitation. Thus the important role of promoting the patient and the family's autonomy, which is consistent with family-centered care is emphasized (Sak-Dankosky et al., 2017: 1). In contrast both the 2010 and 2015 guidelines issued by the American Heart Association have stated that there are mixed results about allowing family members to be present during resuscitation (Lederman, 2016: 5). In addition, a study done by Kramer and Mitchell (2013: 1058) showed that the American Heart Association's position statement noted inadequate evidence that support family presence during resuscitation.

2.4.1.1 Fear of negative consequences

Fear of negative consequences in allowing family presence were identified across the relevant literature, which present as a barrier to this practice (Powers, 2017: 25; Carroll, 2014: 38; Sak-Dankosky et al., 2017: 3). Fears from the family member demanding care might be to the detriment of the patient. Families might become so emotional that it would lead to the prolongation of the resuscitative efforts (Powers, 2017: 25). The healthcare provider's perception is that, due to the brutal nature of CPR, it can be very traumatising for the family and can have a negative impact (Sak-Dankosky et al., 2017: 3). The same was stated in a study done by Duran et al. (2007: 44). Participants believed that it can be psychologically disturbing for families to see the blood and the visual images could be traumatising due to the graphic nature of CPR (Twibell et al., 2017: 114;

Asencio-Gutierrez & Reguera-Burgos, 2017: 55). CPR actions can also worsen the family's grief and has the potential to contribute to post-traumatic stress. Lask of understanding of the situation and the strong emotions that family experience can be contributing to the horror experienced by them, disabling them to stay objective with long- and short-term negative effect on their mental health.

Participants also feared that team communication can be impaired due to increased noice levels and hesitance to correct each other in front of the family (Powers, 2017: 25). Koberich et al. (2010: 31) also mentioned that families can become physically and verbally abusive, or members can either faint, vomit, scream or disturb the other patients. The primary concern was that distractions could alter medical decisions and clinical reasoning during the resuscitation event, thus reducing the effectiveness of patient care and threatening the life of the patient. As such, their clinical judgements could also be affected when families insist on extensive, futile interventions, or when they interrup the team. Resuscitation teams could experience heightened performance anxiety in such scenarios.

2.4.1.2 Disturbed workflow

The influence of family presence during resuscitation on the resuscitation team's performance was described as positive, negative or has had no influence on their performance (Sak-Dankosky et al., 2017).

Disturbed workflow is described as the concern that the physical presence of family members would disturb the workflow of CPR (Sak-Dankosky et al., 2017:3, 33). In a Polish and Finnish study, the findings illustrated that CPR procedures can be disturbed where the resuscitation team is forced to take care of a fainting family member. The lack of room can lead to physical disturbances or emotional behaviour of the family with an impact on the team's ability to focus on the task of saving a life. Furthermore, the family's presence during resuscitation can cause the team stress and insecurity, which negatively affects the team's ability to perform well during the resuscitation (Sak-Dankosky et al., 2017: 3).

Laskowski-Jones (2007: 45) agree and add that the presence of family members can distract the healthcare team members from patient care decisions and tasks, which could impair the resuscitation attempts. He also alluded to the fact that the healthcare team must be aware of the fact that family members can misunderstand the action that they see and that awareness of this can distract the team from their work. In addition, family members cope with anxiety and fear with aggression and anger, which can also hinder the personnel and impair patient care (Laskowski-Jones, 2007: 45). Physicians believe that it is important to assess the family for disruptive behaviour and tendencies, where families might physically impede care or be in the way. They also believe that it is important to consider the disruptive potential of families as they might hinder clear and timely communication among team members (Sak-Dankosky, 2017: 4).

2.4.1.3 Support for the family

In a study done by Sak-Dankosky (2017: 3), the participants mentioned that another barrier regarding family presence at resuscitation is an inadequate amount of staff and professional expertise to attend to the family members' needs. The role of the healthcare provider is solely to focus on the patient in crisis, and not on the family members. The lack of skills on the part of the healthcare provider was also noted as a barrier. In an American study done by Powers (2014: 25), the findings showed that participants were concerned about meeting the family's unique needs. Therefore, the language, culture, religion and educational levels of the family will also be viewed as barriers to family members being present during resuscitation. The same was noted in a study in Germany done by Koberich et al. (2010: 245), which stated that family presence during resuscitation could be implemented into practice if the staff members' criteria and environmental conditions are met. The participants in this study emphasised that the presence of the family during CPR can only take place when adequate staff is there to support the family's emotional and physical needs (Koberich et al., 2010: 245).

2.4.1.4 Staff preparation and support

In the American study done by Powers (2017: 25), it was illustrated that a lack of leadership support was seen as a barrier to invite the family to be present during CPR.They also reported that there is a lack of support from other members of the resuscitation team, mostly from the doctors (Powers, 2017: 25; Koberich et al., 2010: 246). In Poland and Finland, the study conducted by Sak-Dankosky (2017: 3) stated that in order to successfully introduce and implement the practice of family presence during resuscitation, efforts should be made to ensure the readiness for implementation. Such efforts would include that all the staff members should be trained to avoid using medical jargon and to be unprofessional in front of the family. They also mentioned that family presence during resuscitation could help to improve CPR quality and therefore enforce professional improvement training. The healthcare providers also emphasised that well-developed protocols and guidelines should be introduced, which can describe when and in which circumstances families are allowed to be present as well as describe how communication with the family can be improved, thus ensuring better treatment outcomes (Sak-Dankosky et al., 2017: 114; Badir & Sepit, 2005: 83; Al-Mutair, Plummer, O'Brein & Clerehan, 2013: 44).

2.4.2 BENEFITS OF FAMILY PRESENCE DURING CARDIOPULMONARY RESUSCITATION

2.4.2.1 Supportive / positive presence

Some research found that family presence could help to create trust in the resuscitation team members. Therefore the family would be reassured and put at ease when watching the efforts of the resuscitation team (Hassankhani et al., 2017: 131). Participants conveyed that when allowed to be present, family members can see the resuscitation event, their concerns are then decreased or

eliminated following reassurance from the resuscitation team members. Participants also believe that when family members are allowed in the room during the resuscitation event, it can help settle their nerves, which will in turn improve their overall satisfaction with the resuscitation team members. It can also reduce agitation and the need to argue with the resuscitation team members.

2.4.2.2 Personalizing the patient

Davidson et al. (2011: 336) illustrated in their study that family presence during CPR were seen as an enhancing driver. They felt that humanizing the situation was helpful and rewarding. To see and hear everything has positive effects on families. Many of the participants felt it assisted the family to begin the grieving process without blaming the resuscitation team. It also assisted with closure of everything that was done for the patient. It makes breaking the news and the initial uncomfortable period little a easier to handle. Some healthcare providers believe family members should be allowed to be present during what could be the last moments of their loved one's life, because it is the ethically correct thing to do (Laskowski-Jones, 2007: 44).

2.4.2.3 Emotional support

Allowing the family members to participate in end-of-life care as part of the healthcare team, was seen as emotionally supportive. According to participants, if one of the resuscitation team members would take the responsibility of answering the questions of the family, then most of the concerns for both parties (the members of the resuscitation team and patient's family) would be decreased. The support of a family liason person would positively impact on the relationship of the staff with the family members and the needs of the situation. The family members will feel less agitated when procedures performed by the resuscutation team members are explained by such an experienced team member (Hassankhani et al., 2017: 133).

2.4.2.4 Influence on team's performance

Despite previous arguments, family presence during resuscitation can have a positive influence on the team's performance. Sak-Dankosky (2017: 131) reported that the presence of the family improves the attitude of the professional team and their focus on the task. The results of this study also showed that 92% of nurses and 89% of the doctors believed that to appoint one of the resuscitation team members to be supportive of and accountable to the patient's family was very useful and essential to successful implementation. A study done in France by Jabre et al. (2013: 1015) illustrated that the effectiveness and duration of the resuscitation was not affected by the presence of the family members. In addition, the stress levels of the healthcare team were also not affected by the presence of a family member.

2.4.2.5 Patient preference

Participants articulated their considerations of the patient's preference. Although the physicians are cautious about inviting family, they noted that if the patient preferred family to be present, that physicians would more likely consider to invite family (Laskowski-Jones, 2007: 44).

2.4.2.6 Availability of a family support person

In the first published study about family presence during resuscitation, it was found that a family support person has an integral role to play (Brasel et al., 2016: 1438). A nurse or a chaplain can brief the family prior to entering the room, explaining to the family members what they would witness and that the patient's care could not be interrupted. The family support person provides support and information as well as reunites with family following the patient's death. The focus of the family support person must be on the family with no active role in patient care. Ensuring dedicated personnel is available to serve as a family support person is important to increase the medical and nursing staff's likelihood of allowing family presence during resuscitation. Recruiting a teammember who is knowleadgeble about resuscitation and offering support to families during resuscitation is recommended. Educators and managers should identify and train staff to fulfil the role and develop policies and protocols to guide them. Implementing training as family support persons is vital as there exists little guidance about effective preperation for that role (Plagisou et al., 2016: 152). Furthermore, ensuring adequate staffing for the family support role is also another important consideration as participants indicated inadequate staffing as a problem.

2.4.2.7 Policy development to support nurses

Participants showed that there is a perceived lack of leadership support in development of policies by nurses in management, education and advanced practice roles. However, it is recommended that other healthcare team members also offer their support to improve policy implementation. Protocols should be created to guide the family support person to escort the family member out of the room if they are distracting or interrupting patient care. Family presence during resuscitation policies might specify the number of family members that can be allowed in the room. A family support person present during resuscitation is of high importance because they can assist the family member to be in a location that does not impair patient care. Family support persons should be trained to assess the family and incidences where it would be necessary to step out of the room. Study findings also indicate the need for policy and education to address meeting the family's unique needs such as language, culture and religion. In the study done by Laskowki-Jones (2007: 45) it was mentioned that personal preferences of personnel must be explored in order to achieve consensus on how to implement a protocol. Specifically, personnel's opinions and attitudes need to be assessed in order to determine in what circumstances they do or do not support family presence. In addition, it is necessary to consultate with the experts in the field regarding the concept and how to successfully implement such protocols (Laskowski-Jones, 2007: 45).

In a randomised control study that was done by Chapman, Watkins, Rushby and Combs (2011: 20), it was illustrated that participants who had higher educational levels and who specialised in a specific clinical environment perceived having the family members present as more beneficial with few risks. They also perceived having the family members present as beneficial if they had more experience with inviting family members into the room and were more confident. Significantly, 47% of the participants of this study mentioned that they were working in the emergency department and have previously invited the family to be present during CPR. However, also noted is the fact that more than half of the participants have not invited family to be present during CPR. Therefore, the perceptions of the personnel were influenced by the lack of an effective family presence protocol (Chapman et al., 2011: 21). Also indicative of this study, participants mentioned that in order for the successful implementation of such a protocol, the staff must be supportive of this protocol and they need the necessary ongoing education of the process (Chapman et al., 2011: 21).

Advocates of family presence from a variety of countries suggests that family presence advances family-centred care, improves family satisfaction during hospitalisation, strenghtens provider-family relationships and enhances the family's ability to cope with the crisis. Between 50%-96% of family members believe they are entitled to a place beside their loved one during a resuscitation event and once they witnessed a resuscitation they would choose to be present again in the future.

2.5 SOUTH AFRICAN CONTEXT

Gordon et al. (2011: 766) studied the attitudes of nursing and medical professionals in a South African context. The findings illustrated that 80% of the respondants were aware of the practice of family presence during CPR and 57% of the respondents had allowed it previously. Also noted was that 72% female doctors and 47.5% male doctors would allow family members to be present during resuscitation. When doctors and nursing personnel were interviewed and the concept of family presence during resuscitation were introduced, they were willing to consider it in the future (Gordon et al., 2011: 766). During resuscitation, the family is usually escorted out of the room where the resuscitative efforts are being performed (Critchell & Marik, 2007: 311).

The researcher has been working in an emergency unit in a secondary hospital in the Western Cape province where it is the norm to ask the relatives to stay outside of the resucitation area. The family will only be allowed back once the patient has been stabilised or when the news has to be given to the family that the patient did not survive. This practice was also reported upon in a study done by Le Goff (2012: 15) where critical care nurses confirmed that relatives of patients were asked to leave the resuscitation area with active resuscitation. In Le Goff's study, only five of the 11 participants approved the practice of family presence during resuscitation (Le Goff, 2012: 47). Of the doctors, 57% approved the family to be present during resuscitation (Gordon et al., 2011: 765).

In the study conducted by Le Goff (2012: 47), only four participants felt that to allow family members during resuscitation will bring closure and help the grieving process. In the emergency unit, 53% of

the doctors favoured family presence during resuscitation (Gordon et al., 2011: 766). Gordon et al. (2011: 766) found that 72% of the doctors have expressed concerns about the possible traumatisation of a family member. Nine of the 11 participants in Le Goff's study (2012: 16) also shared that same sentiment. In the study of Gordon et al. (2011: 766), the doctors mentioned that a senior member of the resuscitation team should accompany the family during the resuscitative measures, as some of the family members would find it disturbing and see it as a harmful process. The same was identified in the study by Le Goff (2012: 16); families may misinterpret the resuscitative procedures due to graphic television broadcasts, but having a nurse or doctor present to explain the procedures to the family members will minimise the stress that they may experience (Le Goff, 2012: 17). Similarly explained by Gordon et al. (2011: 765), a senior member in the resuscitation team should be allocated to the family during this time. It has also been shown in the same study that chances are greater for family members to be invited during resuscitation if the medical professionals have more experience than those who have less experience. In addition, 70% of doctors found it difficult to terminate the resuscitative event when family members were present, 51% of doctors argued that family members would interfere during resuscitation, and 52% of the doctors would be afraid to have or be aware that the family is there.

2.6 CARDIOPULMONARY RESUSCITATION IN RELATION TO HEALTH LEGISLASTION IN SOUTH AFRICA

According to McQuoid-Mason (2013: 223), the Constitution and the National Health Act (Act 63 of 2005) states that no patient can be refused emergency medical treatment. The do-not-resuscitate (DNR) order require that certain patients should be given CPR to save their lives (McQuoid-Mason, 2013: 223).

2.6.1 The meaning of emergency medical treatment

The National Health Act (63 of 2005) does not define emergency medical treatment; however, the Constitution defines it as a dramatic, abrupt situation or event that is of a passing nature in terms of time that can be cured through medical treatment. Moreover, emergency medical treatment refers to the acute episode of a disease that can be rectified, rather than an incurable chronic disease (McQuoid-Mason, 2013: 223). Therefore, the need for emergency medical treatment arises when a person is faced with the possibility of death, serious bodily injuries or deterioration in health that results from a sudden situation or event but not as a result of a chronic illness (McQuoid-Mason, 2013: 223). Furthermore, the patient will not be entitled to emergency medical treatment if faced with the real possibility of death as stipulated in the Constitution. Palliative care will then still be allowed (McQuoid-Mason, 2013: 224).

2.6.2 Futile medical treatment

Futile medical treatment can be defined as medical treatment that offers no reasonable hope of recovery or improvement or from which the patient is unable to experience any benefit. However, the relationship between emergency medical treatment and DNR orders tend to fly in the face of medical professionals because they deny certain patients medical treatment in a threatening situation (McQuoid-Mason, 2013: 223). According to the Constitution's interpretation of emergency medical treatment, it cannot be because the legal meaning is confined to situations that are of passing nature in terms of time and not to the underlying fatal condition that is incurable (McQuoid-Mason, 2013: 223). DNR orders will only be issued in situations where attempts to apply CPR would be futile or against the wishes of the patient or persons legally able to consent on the patient's behalf. Such orders only apply to CPR and do not affect the other treatments such as nutrition or pain relief (McQuoid-Mason, 2013: 223).

2.6.3 When will cardiopulmonary resuscitation be considered futile?

CPR will be futile when the doctor in charge of the patient's care command that the patient will not be resuscitated even if it is against the wishes of the patient, the patient's family and friends (McQuoid-Mason, 2013: 224). The doctor and other healthcare professionals have no legal duty to provide futile treatment to patients even if it is requested by the patient, their relatives or persons close to them (McQuoid-Mason, 2013: 224). Furthermore, when CPR is hopeless and the patients or their family members request continued treatment, they must be given the option of transferring the patient to another facility where such treatment is available (McQuoid-Mason, 2013: 224). However, if this option is still refused and the healthcare team considers the treatment to be futile, then the treatment can be withheld or withdrawn (McQuoid-Mason, 2013: 224).

2.6.4 When can do-not-resuscitate orders lawfully be used?

According to McQuoid-Mason (2013: 224) the DNR can be initiated when a patient makes an informed decision that s/he refuses resuscitation or when the patient has an advanced directive in place, such as a living will. A DNR can also be initiated when the doctor, who is in charge of the patient's care, decides that medical treatment will not restart the patient's heart or breathing (such as when a patient is dying from an irreversible condition). Another motivation to initiate a DNR is when the doctor, together with the patient and his/her family, have reached an agreement that the benefits are outweighed by the risks involved.

2.7 SUMMARY

Family presence during CPR is a controversial concept, especially from the healthcare provider's perspective. In this chapter, the literature review showed that there are benefits for the patient, the family as well as the healthcare providers in allowing such family presence. At the same time, there are also risks involved for all the parties involved. Some risks that were identified in the literature are

that there are not enough resources to implement such a practice and to accommodate only the family. The lack of training and education for healthcare providers in relation to this concept is also considered to be a risk.

2.8 CONCLUSION

Chapter 2 provided an informative discussion of the literature relating to the concept under study. The literature indicated that there are benefits and risks involving the practice of family presence during CPR situations for the patient, the family as well as the healthcare provider.

In chapter 3 the research methodology that was utilised for this study will be discussed to explore the perceptions of medical officers and nursing professionals about the practice of family presence during CPR.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 consists of the literature review about the practice of family member presence during globally, as well as nationally. In this chapter, the research methodology will be discussed. The purpose of this research study was to explore and describe the perceptions of emergency care medical officers and registerd nurses about family presence during CPR at the emergency centre of a secondary provincial hospital in the province of the Western Cape in South Africa.

A research methodology is described as the total strategy, from the problem identification to the final steps of data collection and analysis (Burns & Grove, 2011: 234). The research design, population and sampling, pilot study, data collection, data analysis, summary and conclusion will be presented in this chapter.

3.2 RESEARCH QUESTION

What are the perceptions of medical officers and registered nurses about family presence during CPR in a secondary hospital in the province of the Western Cape in South Africa?

3.3 OBJECTIVE

The objective of the study was to explore and describe the perceptions of registered nurses and medical officers about the practice of family presence during CPR.

3.4 STUDY SETTING

Burns and Grove (2011: 40) define the setting as the location for conducting research. The research was conducted at a secondary provincial hospital in the Western Cape provinc of South Africa.

This secondary hospital, which accommodates 320 beds, provides a 24-hour emergency service in the semi-rural area to three smaller towns, 60km away from the large Cape Town metropolitan area. The emergency centre has an annual census of approximately 47 000 patients per year and an average of 160 patients over a period of 24 hours. An average of 23 resuscitation events per month is performed, whether due to a medical condition or trauma. In this level two emergency unit, the most common types of cases people are admitted with are upper body stabwounds, orthopaedic emergencies, abdominal emergencies and traumatic brain injury emergencies. Common types of medical emergencies are neurological emergencies, cardiac emergencies and respiratory emergencies. The types of personnel who are on duty on a daily basis are, three specialised registered nurses, two non-specialised registered nurses, seven emergency medical officers and two senior consultants to manage the emergency cases.

3.5 RESEARCH DESIGN

A research design, such as the exploratory-descriptive design as described by Burns and Grove (2011: 254), is the blueprint of a study. The semi-structured interviews used was based on the aim and objective of this study. Yin (2014: 18) describe a research design as the logic that links the data to be collected to the initial question of the study.

The researcher used a qualitative approach, with this explorative-descriptive, design by means of individual interviews, to answer the research question. Qualitative research is an approach that describes life experiences and perceptions of persons involved. It is a way of giving significance to such human behaviour and experiences (Grove, Burns & Gray, 2013: 57). Therefore, by exploring the perceptions of medical officers and registered nurses about the practice of family presence during resuscitation, the researcher would gain new insights and improve comprehension of the phenomenon under study (Grove et al., 2013: 57). A quantitative approach would not be appropriate, as it is more objective and a formal process of generating numerical information about the concept. This research question needs to be answered subjectively as it focuses on the study participants' perceptions (LoBiondo-Wood and Haber (2010: 583).

The exploratory-descriptive research study design created an opportunity for the researcher to understand the needs, the preferred outcomes as well as the opinions of a particular population (Grove et al., 2013: 66). the perceptions of the medical officers and registered nurses in this case about the practice of family presence during CPR.

3.6 POPULATION AND SAMPLE

A population is a particular group of individuals who have one or more characteristics in common and who becomes the focus of the research (Grove et al., 2013: 351). The population is furthes described as all the elements (people, objects, events and substances) that meet the sample criteria for inclusion in a study (Burns & Grove, 2011: 51). Lastly, LoBiondo-Wood and Haber (2010: 583) define a population as a well- defined set that has certain specific properties.

Sampling involves the selection of a group of individuals with which to conduct the study (Grove et al., 2013: 351). Therefore, a sample represents the selected group of people from a population that are included in the study (Grove et al., 2013: 351).

3.6.1 Population

In this reseach study, the study population consisted of emergency care nursing and medical personnel who were working in the emergency centre of a regional provincial hospital. A target population of a total of 30 healthcare providers, which comprised of 14 emergency doctors and 16 registered nurses, was included in this study.

3.6.2 Sampling method

A purposive sampling method was used to select participants to partake in the interviews for this study. This a process where the researcher intentionally selected participants based on the fact that the participants will be able to provide information on the topic, as described by Grove et al. (2013: 365). LoBiondo-Wood and Haber (2010: 583) postulate that in purposive sampling, the researcher looks for a specific participant who can illuminate the concept under study. The purposive sample of the registered nurses and medical officers that were chosen had in-depth knowledge and experiences regarding the practice of family presence during CPR. Purposive sampling was applied as follow in the study:

The researcher, with permission from the area manager, informed the 30 participants who met the inclusion criteria about the information sessions to recruit participants for the study. The information sessions were held by the primary researcher with the nursing and medical healthcare providers on 9 and 10 August 2018. The information sessions focused on the research and its purpose. Those who indicated their willingness to participate voluntarily, gave a date and time convenient to them to be interviewed by the fieldworker. They gave verbal consent when they indicated their willingness. The participants were informed that they have the right to discontinue with the research study at any time. The final sample from this population for the study comprised of four willing emergency doctors and six registered nurses that were directly involved with resuscitation and could provide in-depth knowledge about this phenomenon. The participants agreed on the specific days that were scheduled to do the interviews.

3.6.3 Inclusion criteria

Burns and Grove (2011: 290) state that the inclusion criteria are the list of characteristics the research population must have to be suitable for the study. The inclusion criterion for this study was that the participant should:

- Be employed in the emergency centre of the hospital where the study was conducted.
- Be registered as a registered nurs or medical officer who provide care to patients in the emergency centre of the hospital.
- Have at least one year of experience in the emergency centre.

3.6.4 Exclusion criteria

As described by Burns and Grove (2011: 699) the exclusion criteria are the criteria that exclude a person from participating in a study. The following exclusion criteria were applied in respect of the study participants:

- People in management positions related to the emergency centre but who did not provide direct nursing or medical care to patients, or who were not involved in emergency situations.

3.7 INTERVIEW GUIDE

Interviews can be described as a flexible technique that allows the researcher to discover meaning in greater depth (Burns & Grove, 2011: 351). Data were abtained from interviews, using a self-developed, semi-structured interview guide.

The guide was formulated by the researcher with the research question in mind and questions were developed which participants would answer to convey their perceptions about family presence during CPR

The semi-structured interview guide comprised of four open-ended questions (Appendix 6). The opening question was “How long have you been working in this emergency centre?. The interview guide allowed flexibility for the intervierwer in asking questions as well as for the participants in answering it, and enabled probing in order to gain more in-depth information on the matters mentioned during the interview.

3.8 PILOT STUDY

According to LoBiondo-Wood and Haber (2010: 236), a pilot interview is a smaller version of the main study (Burns & Grove 2011: 544). The reason for initiating a pilot interview was to discover any problems that might hinder the interview process and to determine if the interview guide were sufficient. The pilot interview was also used to determine the feasibility of the study and establish the fieldworker’s competencies with the interview technique.

Written informed consent was obtained and the interview was digitally recorded and transcribed. The pilot interview was done by the fieldworker with a selected participant of the population at the emergency centre of the secondary provincial hospital. One participant was used for the pilot interview successfully wiith no adaptesions necessary to the guid. The pilot interview took approximately 30 minutes to complete. The data of the pilot interview was included in the data analysis of the main study as it was relevant to the research guestion and answer.

3.9 DATA COLLECTION

Data collection began on 17 August 2018 and ended on 21 September 2018 after data saturation was reached. The interviewing time was scheduled during lunchtimes, which did not interfere with their daily activities and patient care in the emergency centre. Each interview took about +-30 minutes whereafter the interviewer thanked the participants for their time. The researcher took her time to reflect after each of the interviews. Member checking was facilitated by the fieldworker during a follow-up meetings on 27 and 28 September 2019 with each of the participants that validated the transcribed document of their specific interview.

Data collection for this study comprises of the fieldworker collecting the information from the participants by means of individual interviews to find answers to the research question (Grove et al., 2013: 523). The data was collected from participants by an independent fieldworker (see 3.9.1) at the emergency centre of the secondary provincial hospital after participants gave written consent. A convenient venue, date and time were confirmed with the participants and all interviews were conducted in an additional doctors' rest room in the emergency centre away from all the noise. The participants who indicated their participation informed the researcher what time would be convenient for them to be interviewed on the scheduled days of the interviewing. Therefore, the researcher informed the fieldworker of the times of the participants so that it would not interfere with patient care and activities Special arrangements were made that the unit's senior consultants were on duty so that they could care for patients when the participants were busy with the interviews. Subsequently, the staff could not see who were interviewed. Special arrangements were also made in advance with the fieldworker to accommodate participants should they wish to be interviewed on a different time and place convenient to them. However, all participants was happy to be interviewed on the days they were scheduled to work. Subsequently, no hindrances were observed during the interviews and the timeframe did not interfere with the daily activities and patient care in the emergency centre. The fieldworker made sure that the consent forms were signed and refreshments were provided to the participants.

The primary researcher is a senior registered nurse working in this emergency centre. The fielworker employed for the purpose of this study worked in the private health sector. The fieldworker completed a training course in qualitative interviewing skills, completed a master's degree in nursing and conducted 20 individual interviews. The fieldworker is fluent in English and Afrikaans and could conduct the interview in Afrikaans as it was a priority to make sure that the participants were comfortable to do the interview in their preferred language. The fieldworker was paid for her services.

3.9.1 Collection of the data

The fieldworker made her role and the role of the participants in the research study known prior to the interviews and had conversations with the participants to ease the atmosphere before the interviews commenced. The fieldworker obtained verbal consent as well as written consent from all participants to use a digital recording device to record the interviews. Open-ended questions were drafted to engage with participants so that they could be comfortable and participate freely in conversation with the fieldworker. The fieldworker also used member checking to verify the information that the participants provided. A second digital recording device was also available, should any technical failure of equipment occure, as advised by De Vos, Strydom, Fouche and Delport (2009: 310). The interviews were intended to gain insight into the regesterd nurses' and medical officers' perceptions about family presence during resuscitation at the emergency centre of a regional provincial hospital in the province of the Western Cape in South Africa.

Probing was used during the conducting of the interviews in order to gain information-rich data regarding their perspectives on the research question. Probes, as described by Burns and Grove (2011: 85), are queries that are made by the researcher to obtain more information about a particular interview question. Probes that were developed for the interview process were as follows:

"Tell me more of your experience in family resuscitation?"

"Can you explain what you mean by that?"

Initially, during the information sessions, 12 participants indicated their willingness to participate in the study. However, two of the participants declined to be interviewed and withdrew from the study before the interview could take place, with their rights upheld by the fieldworker. No other issues during the collection of data were reported. Prior to the interviews, a sign was made visible in the passage to inform staff that interviews were taking place. Digital recordings were made during the interview, which allowed the fieldworker to pay more attention to the participants as well as the interview itself. In addition to the recordings, fieldnotes were made by the fieldworker. Data saturation was reached with the 10th individual interview as no new information were observed in the data collected (Ando, Cousins & Young, 2014: 1). Examples of fieldnotes:

Participant 2: Sample of fieldnotes the fieldworker wrote down during and after interview

- Information of family – it is an important aspect if the family can be provided the option.
- There is a ckoice between patient rights and family rights.
- A practice suct as this is beneficial for the family and the healthcare provider-acknowledgement is important
- There is also a difference between CPR of medical patient and CPR of a trauma patient and that information is important together with a dedicated team approach.
- Acception, for the family is important as well as communication to the family is important.
- Family that needs to be educated regarding the resuscitation prcess and the follow up after that.
- Personnel shortage is a big problem – normal ask a senior sister who is not actively involved in the resuscitation to help if there is shortage of staff.

3.9.2 Handling of data

The fieldworker clearly labelled the interview recordings and fieldnotes with an interviewee number as a pseudonym after each interview to ensure the anonimity of the participants. The primary researcher received all the recordings and fieldnotes in a sealed envelope from the fieldworker.

The primary researcher, who received training in transcribing from Stellenbosch University, transcribed the recording of the interviews verbatim. The reseacher wrote the specific interview number, thereafter transcribed each and every word from the start of the interview, right through the

questions of the fieldworker and answers of the specific participant up to the end of the interview. This was a slow and intense activity, as the participants talked fast at times and added some slang and English wording in between sentences. The researcher checked spelling, grammar as well as commas and fullstops. After each draft of all ten transcripts, the researcher listened to the recording again and followed on the conversation of the fieldworker and the specific participant.

All transcripts that were done were labelled according to the participant number of the recordings, password protected and kept safe in an office at the researcher's house where only the primary researcher has access to it. The researcher handed over the transcriptions to the fieldworker for the member checking meetings. The data will be destroyed after five years, according to protocol.

After the transcription process and member checking, the process of data analysis followed.

3.10 DATA ANALYSIS

Qualitative data analysis is a process of scrutinizing and interpreting the data in order to elicit meaning, gain understanding and to develop empirical knowledge, as described by Grove et al. (2013: 279).

The researcher used qualitative content analysis, as described by Hsieh and Shannon (2005: 1279), to describe the concept under study and to increase the researcher's understanding of this phenomenon. In addition, interview data for explorative-descriptive qualitative studies require content analysis to answer the research question. As described by Elo et al. (2014: 1), qualitative content analysis is usually used for analysing qualitative data where the data collected are unstructured, such as the data gathered in interviews. Therefore, the advantages for this type of data analysis method is that it is a very unobtrusive means of analysing interaction. Content analysis provides more insight into complex human thought and their language used. It also maintains a high level of simplicity and, as with other forms of research, it is very practical to complete. However, the disadvantage of this method is that it is very hard to assess the validity of the analysis because of the subjective nature of the individual's opinion. It provides limited data as it is only recorded content that is being analysed.

Grove et al. (2013: 280) holds that the qualitative researcher needs to become familiar with the data. Therefore, the researcher was involved with the transcripts and the researcher read all the information repeatedly so that the researcher could immerse herself and become familiar with the data collected. Notes and headings were written down to develop codes by highlighting the words that appeared to identify relationships within the data (Elo & Kygnas, 2008: 109; Hsieh & Shannon, 2005: 1279). This was followed by coding, which is a process of reading data, breaking the text into parts and labelling that part in text, as referred to by Grove et al. (2013: 281).

The principle of bracketing was also applied by the researcher in order to safeguard against misinterpretations of the results. Bracketing can be described as the process where the researcher

sets aside his/her own knowledge regarding the study and focus on the participants' experiences (Grove et al., 2013: 60). The researcher listened to the recording of each interview, typed it word for word as the participant said it and put it forward as it was captured in the data analysis. It also helped when the fieldworker did member checking with the participants to verify the meaning of information provided during the interviews, so that the researcher could interpret the findings as is the interviewee meant to be interpreted. According to Grove et al. (2013: 281), content analysis is designed to classify words in text into categories. Therefore, the emerging categories was organized into meaningful clusters. Important concepts were characterized and rearranged regularly during discussions with the supervisor where significant themes and categories were identified. This ensured that there was agreement on the themes and categories. The process of conventional content analysis, as described by Hsieh and Shannon (2005: 1279), is detailed in the following sections.

3.10.1 Reading the data

The researcher listened to the recordings of the interviews with the participants two to three times, and then transcribed the conversation word for word. Thereafter, the researcher listened to the recordings repeatedly with the transcripts, as one would read a novel, to obtain a sense of the whole interview. During this process, the researcher familiarized herself with the information that was disclosed during the interviews, and immersed herself in the data.

3.10.2 Notes and headings

The researcher established the units of analysis where the researcher read one sentence to two sentences and sometimes a paragraph. The researcher carefully read each transcript and highlighted the text that appeared to describe the perceptions of medical officers and nursing professionals about family presence during CPR, as illustrated in Table 3.1. The researcher then wrote in the margin words or phrases that stood out in the information. The researcher repeated the process with all the transcripts of the interviews conducted for the study. From the words that were highlighted and the notes that were made, codes could then be developed. Verification of this was done by the supervisor.

Table 3.1: Example to illustrate an extract of transcript 2 and notes

Transcript extract: Participant 2	Notes
"n Dokter wat na die familie gaan om met hulle te gesels en vir hulle te vertel dat die pasiënt lyk nie goed nie en dat ons alles in ons vermoë doen en ook aan hulle die opsie bied om in die kamer te	Communication (informed) family during CPR Information about the medical status of the patient Give family option to witness

gaan en sien wat alles gedoen word. Daardie persoon moet ook aan die familielede verduidelik wat die verskillende mense doen rondom die pasiënt om die pasiënt te probeer red en kyk of ons weer die hart aan die gang te kry. Party van die familielede is maar geskok en hulle wind is maar redelik uit hul seile uit as hulle daar staan veral in 'n trauma situasie waar hulle dit nie verwag het nie. So jy kry ook die wat histeries aan die huil gaan en die wat letterlik net daar staan met hulle groot oë en kyk. Dan is daar ook party familielede wat daar staan totdat ons dit 'call' en sê dit is klaar en ook diegene wat wel sê 'okay' hulle het nou genoeg gesien en dat hulle eerder wil buite staan en dan kan die dokter hulle inlig wat aangaan."	Explain to family medical treatment (information) Shocked reaction of family Shocked (idiom) Not expected Family hysterical reaction Family cry Family is astonished Family watch and wait when all done Family verbalised that they had seen enough and decided to wait outside the resus room for detailed information about the resus

3.10.3 Coding

Labels for the codes emerged from the words and phrases highlighted and are reflective of more than one key thought, which became the initial coding scheme (Hsieh and Shannon, 2005: 1279). The researcher did extensive data reduction during the coding process (see table 3.2). Once all the transcripts had been coded, the researcher read the transcripts again, broke it down into parts and examined all the data within that specific code.

Table 3.2. Example to illustrate notes to codes

Notes	Codes
Communication (informed) family	Communication with family while CPR

Information about the medical status of the patient Explain to family medical treatment (information) Doctor to give detail about the resus	Medical knowledge (information)
Give family option to witness	Family option
Family decide watch and wait when all done Family verbalised that they had seen enough and decide to wait outside the resus room	Family decision
Shocked reaction of family Shocked (idiom) Not expected Family is astonished	Shocked reaction(family)
Family hysterical reaction Family cry	Hysterical reaction(family)

The researcher labelled the parts of the data that had similar codes and combined them after which the researcher split the codes that were different from each other into categories. Therefore, the codes are organized into categories based on how different codes are related and linked together. After the researcher coded the data, the researcher took each transcription and placed the codes from each interview in a spreadsheet document. Every code that was similar to one another was placed together in a category. The categories that emerged were used to organize and group the codes into meaningful clusters to form categories. Figure 3.3 illustrates how categories were organized.

Table 3.3: Examples of how categories were organised from codes

Categories	Codes
Information	• Medical knowledge(information)
Communication	• Communication during CPR
Family choices	• Family option

Family reactions	• Shocked reaction(family) • Hysterical reaction(family)

3.10.4 Themes

Each of the interview transcriptions were treated in the same way. Themes were formed from the categories (Table 3.4). Categories were sorted, examined, combined and narrowed which had a relationship to form themes. Furthermore, themes were reviewed in relation to the codes and the topic which is the perceptions of medical officers and nursing professionals about family presence during cardiopulmonary resuscitation. Some of the initial codes, categories and themes were reworked into other themes. In this way the researcher focuses on what fits together, thereby bringing forward the story of the perceptions of medical officers and nursing professionals about family presence during cardiopulmonary resuscitation. For example, the communication that took place during the resuscitation process were information related, therefore the theme: Information communication

Table 3.4: Example to illustrate themes from categories

Theme	Categories
Information communication	Information Communication

Knowledge generated from the content analysis process was based on the participants' unique perspectives and grounded in the actual data of the interviews.

Interview recordings, transcripts and fieldnotes are locked away in a safe at the researcher's home and will be kept for 5 years after which it will be destroyed. Further ethical considerations are fully described in chapter 1.

3.11 TRUSTWORTHINESS

According to LoBiondo-Wood and Haber (2010: 128), with trustworthiness there should be a relationship between the study's themes and the quotes. Trustworthiness refers to the rigor of qualitative research (LoBiondo-Wood & Haber, 2010: 128). The following aspects were applied to this qualitative research study to ensure the rigor of the study, namely credibility, transferability, dependability and confirmability, as described by Lincoln and Guba (1985: 316). Bias was avoided as the researcher made sure that she stayed objective and conscious of what is said during the data analysis process. When the researcher transcribed the data, she ensured that she listened to the information and typed it precisely as the participants conveyed it during every interview. The

assistance of the supervisor and co-supervisor also helped to provide different perspectives and confirm the themes of the data that was collected.

3.11.1 Credibility

Credibility refers to the internal validity where the researcher will attempt to provide an accurate description of the concept under study as described by Shenton (2004: 63-68). Credibility of data was ensured through member checking and peer review sessions held with the supervisor and fieldworker. This assisted with the credibility of the study where different viewpoints were verified against others. In addition, the fieldworker used member checking with participants to clarify the themes that have been generated during the interview to summarise and check that the data was accurate (Creswell, 2014: 251). Carlson (2010: 118) explains that member checking is where "participants validate the data they provided during interview". Member checking was done with all participants including the sharing of transcripts, themes and conclusions. The fieldnotes also added value to the data collected from the interviews as it contributed to the views of how the participants perceived this concept in real life.

3.11.2 Transferability

Transferability refers to the extent to which findings from one situation can be applied to another situation and settings (Shenton, 2004: 70). Barnes, Conrad, Demon-Heinrich, Graziano, Kowalski, Neufeld, Zamora and Palmquist (2014: 2) declare that transferability is a process that is performed by readers. Therefore, the readers become familiar with the content of the study and must make their own decision if the results of this research study would be the same in their own contexts.

In this study, the researcher believes that readers can identify with the study content of the perceptions of nursing professionals and medical officers about family presence during CPR in the emergency centre of a provincial hospital in the Western Cape province of South Africa. However, it is their decision if the findings of this study are relevant to their particular situations.

In this study, transferability was ensured by including a detailed research process as well as the findings of this study. Therefore, the researcher is optimistic that the knowledge will provide insight into the perception of medical officers and nursing professionals about family presence during resuscitation at the emergency centre of the secondary provincial hospital. The researcher persisted with data collection until no new information emerged, indicating that data saturation was reached (LoBiondo-Wood & Haber, 2010: 236). Purposive sampling helped toward transferability. These participants gave rich information as they experienced the trauma that families might experience, as well as rewarding feeling experience when they allow the family to be present during CPR situations.

3.11.3 Dependability

Dependability refers to reliability, which entails whether similar results will be obtained when the study is replicated in a comparable context using the same methods and participants (Shenton, 2004: 72). It is also a criterion proposed by Lincoln and Guba (1985) to establish trustworthiness and requires a review. The person who acted as the auditor used the same processes and procedures that were used by the researcher (Shenton, 2004: 71-72). In this study, the data collection and analysis were verified by the supervisor and co-supervisor. The researcher and the academic supervisor listened to the audio recordings. Transcripts were reviewed and thematic coding during data analysis was verified. This study will go through an external and internal moderation evaluation to further contribute to dependability.

3.11.4 Confirmability

Confirmability as described by Shenton (2004: 72) refers to whether the researcher has attained objectivity when the findings of the study were communicated from the data obtained and not from the bias of the researcher. Bias is of great concern in any aspect of a research study (Grove et al., 2013: 197). This is the reason why a fieldworker was recruited to the interviews. In this way, the collection as well as the findings of the data obtained could not be influenced by the researcher. Furthermore, an audit trail was created by way of a reflective journal kept by the researcher from the start to keep record of the ongoing thoughts regarding previous experiences of the phenomenon under study (Polit & Beck, 2014: 326). Member checking help to verify the data that the participants meant to convey during the initial interview. Discussions were held with the supervisor to ensure that the data collected by the fieldworker were an accurate reflection of the interviews that took place. Accurate from interviews also enhanced confirmability.

3.12 SUMMARY

During the research methodology process, the researcher was primarily responsible for transcribing the information that was obtained from the conversations between the fieldworker and the participants. The data collection process was time consuming in ensoring the availability of the fieldworker to do the actual interviews as well availability of participants. The researcher had to concentrate on what was said during the interview, and to transcribe it accurately. Time management was a great challenge during the transcrip of all the information, but rewarding in the end.

3.13 CONCLUSION

Chapter 3 detailed the methodology used in this research study, including the research design, study population as well as the pilot study. The process of data collection and data analysis was described. An exploratory-descriptive research design with a qualitative approach was used to describe and gain insight into the perceptions of medical officers and nursing professionals about the practice of

family presence during CPR at the emergency centre of this regional provincial hospital. In the following chapter, the findings of the research study will be presented and discussed in detail.

CHAPTER 4

FINDINGS

4.1 INTRODUCTION

Burns and Grove (2011: 91) describe data analysis as the interaction that occurs between the researcher and his/her involvement in the data collection. The findings of the data analysis are discussed in this chapter. The discussions are structured according to the themes and categories based on the collected data. The participant's quotes will be in italics.

4.2 PURPOSE

The purpose of this study was to explore and describe the perceptions of medical officers and RPN's nurses about the practice of family presence during cardiopulmonary resuscitation (CPR). Participants were interviewed and verbatim transcripts were analysed by means of a content analysis process. Trustworthiness was maintained throughout the data analysis process to maintain neutrality and confidence in the findings.

Findings confirmed that it has positif and negative effects. The correct information, and bereavement, together with having an effective team approach, lack of resources, staff shortages and secondary trauma. Recommendations regarding the practice and the implementation thereof will be presented.

4.3 SECTION A: BIOGRAPHICAL DATA

The study population consisted of 10 participants. A total of six emergency registered nurses and four emergency care medical officers, were interviewed. The years of experience of the registered nurses ranged from four to eleven years, with four of the registered nurses specialised in trauma-based care. Of the six registered nurses, one was a male. The medical officers' years of experience ranged from four to thirteen years. Of the four medical officers, two were male. All participants knew beforehand about the scheduled interviews. All of the interviews were conducted in Afrikaans, which was the participants' language of choice.

4.4 SECTION B: THEMES EMERGING FROM THE INTERVIEWS

In this section, the findings of the research are presented in the form of themes and categories. Table 4.1 summarizes the interview outcomes. The findings will be discussed under the following headings: Information communication, benefits and challenges of family presence, family's choices and reaction, type of CPR case and professionals' interactions and skills.

Table 4.1: Final themes

Theme 1: Information communication

Categories	**Codes**
1.1] Information	Information from and to the family Confidential information Understandable information Medical knowledge
1.2] Communication	Transmission of information Message Communication on arrival Communication during CPR Communication after CPR
Theme 2: Benefits and challenges of family presence	
Categories	**Codes**
2.1] Benefits of the practice of family presence during CPR	Family benefits when present during CPR Benefits of family presence for medical officers and nursing professionals
2.2] Challenges when family presence during CPR are practiced	Family challenges when being present during CPR Medical officers and nursing professionals' challenges when family presence during CPR are practiced Emergency department challenges when family presence during CPR are practiced
Theme 3: Family's choices and reactions	
Categories	**Codes**
3.1] Choices of the family	Family options during the CPR process Family preferences during the CPR

	process Family decisions during the CPR process
3.2] Reactions of the family	Rational Hysterical Resentful Shocked
Theme 4: Type of CPR case	
Categories	**Codes**
4.1] Prognosis	Diagnosis Scenario intensity
4.2] CPR case type	Multiple cases Types of cases Procedures
4.3] Age of patient	Pediatrics Young adult Older patients
Theme 5: Professionals interactions and skills	
Categories	**Codes**
5.1] Interactions of professional workers during the resuscitation process	Teamwork Empathy and sympathy Professional duty
5.2] Skills of the professional workers during resuscitation process	Decision-making Advocate Collaboration

	Provide comfort

4.4.1 Theme 1: Information communication

The importance of communication of information to family in the resuscitation was significant in the feedback of all the participants. The content of the information about the CPR activity is transmitted by the action of communication. Participants argued such communication could lead to the success of the CPR activity and the relationship of the team with the family. The information communication related to the different informational aspects that are conveyed from and to the family from the entrance to the emergency, unit throughout the resuscitation, and up to the outcome of the resuscitation activity. The catergories formed from the themens are into the aspects of information abd communication:

Category 1.1: Information

Important aspects that eminated from the interviews were the importance of receiving and providing the correct information in an understandable manner, in a language with which the family is comfortable during CPR. Each code will be explained in detail.

4.4.1.1 Information from and to the family

The participants have indicated that it is important to get information about the history and the complains of the patient to facilitate the CPR process.

> *"[J]ou normally sent someone to the family to get information about the patient and to find out whether the person has been sick or not "* (Participant 2).

> *"…we are not always aware of family outside ..... to get information and history regarding the patient "* (Participant 5).

Providing information to the family was equally important during the data analysis process. Furthermore information, whether you receive or provide it, what you want must be on a level where the family can start to prepare themselves for the outcome, alwos if it is a negative outcome. As a family, it might help then to find acceptance of the outcome.

> *"..... you provide information to the family so that they can prepare them mentally for what is about to happen, so that they start to accept what is happening,so that when we decide to stop with the resuscitation, they will accept it "* (Participant 9).

> *"...there is always someone to go to the family to explain what is busy happening inside and also to prepare them of the possibility that their loved one might not make it "* (Participant 10).

4.4.1.2 Confidential information

Participants also mentioned that often confidential information is disclosed to family members. Sometimes it could be information that no one knows about; it is, therefore, important to maintain the patient's privacy. The patients' rights must be safeguarded.

> *"[I]t is sometimes difficult with an active resuscitation to give information to people without violating the rights of the patient "* (Participant 5).

An issue that presented during the interview was to which family member confidential information should be disclosed regarding their loved one.

> *"…preferably the immediate family, that is for instince the mother, father and children "* (Participant 9).

> *"The person who is allocated to talk to the family is sometimes left with having to make the decision to discern between immediate family or family in general to provide information to " (Participant 10).*

4.4.1.3 Understandable information

The participants conveyed during data analysis that information to the family must be understandable obtain insight about what is happening and prepare themselves for the outcome. The family also need to be kept updated about the logical CPR process. An issue that was raised was the fact the families can easily misinterpret information. and information needs to be communicated in an understandable manner to decrease miscommunication and quarrels between family members.

> *"[W]hen doctors are calling for the family while we are busy with CPR and just to say that we are busy trying to do..... , this is why we are doing certain things, but it does not look like we are going to save the person's life. Then they would ask them if they understand what is busy happening with their loved one"* (Participant 8).

> *"Sometimes the person who are allocated to be with the family are placed in an difficult position because you need to be knowledgeable in order to provide the family with information as well as to convey that information in a understandable manner "* (Participant 10).

> *"[J]ou, get the people who internelise everything, who only stares and looks at everthing and who cries that sort of confirmative cry, to say that they understand what is going on ""* (Participant 7).

Participants mentioned that it is important for the family to understand the CPR process. If the family is provided the option to be present and if they decide to do so, the person who is accommodating them should take them through the resuscitation process step by step.

> *"We know what the diagnosos is, we know what is going to happen but the family do not know. So it is important for us to take them through the process in an understandable manner."* (Participant 3).

> *"[T]he person who is talking to the family must have the knowledge to provide the family with information in a manner that they can understand "* (Participant 10).

1.1.4 Medical knowledge (information)

The participants spoke of the importance of using layman's terms in conveying the information. Although generally family members do not have medical backgrounds and do not know medical terminology they would know that everything possible is being done or was done for their loved one.

> *"[w]e are trying mostly not to use medical terminology and to speak in Afrikaans and/or English so that they can understand "* (Participant 2).

> *"[J]ou must talk in the language in which the family are comfortable and can understand"* (Participant 3).

Category 1. 2: Communication

The facilitation of communication during resuscitation ensures involvement of the family during resuscitation. Different aspects of communication were voiced by the participants and discussed below:

Code 1.2.1 The transmission of information

The transmission of information was also an important aspect that the participants mentioned. Family members would never be allowed to enter the resuscitation room without having spoken to beforehand a medical officer or someone who is knowledgeable. One of the talking points initiated by the participants was that the person who will be allocated to transmit information the family must be knowledgeable when communicating with the family.

> *"[I] think we will never allow family in the resus room without talking to them. So there must always be someone who can explain things to them"* (Participant 2).

"...there must be someone outside with theme giving them a life update about what is happening to their loved one" (Participant 6)

Code 1.2.2 The specific message

Part of the communication process, is the message. Participants spoke of how the message must be given to family by the person who is allocated to accommodate them. That person must act as the liaison between the resuscitation team and the family.

"...the communication to the family must be right " (Participant 3).

"Communication to and from the family is of utmost importance and the responsible person needs to be the liason between the resus team and the family who are with the patient " (Participant 10).

Code 1.2.3 Communication on arrival of family

A family in crisis needs assurances from the start. Therefore, the participants spoke of the importance of communication, especially when the family arrives.

"[J]ou normally sent someone to the family to get information regarding the patient, and to know if the patient has any diseases" (Participant 2).

" [W]e start at the beginning where the patient arrived at the hospital with the history the family gave us" (Participant 9)

Code 1.2.4 Communication during cardiopulmonary resuscitation

Participants also spoke of keeping the family updated about their loved one's condition while the resuscitation team is fighting for his/her life. The participants spoke of being a mediator or liaison between the family and the resuscitation team.

"[W]e want someone to go to the family to give them a live update, on what is happening with the patient " (Participant 6).

"...that there will always be medical personnel to go to the family to get information regarding the patient, then to give the family an update as to the diagnosis and prognosis of the patient as well as the way forward " (Participant 10).

Code 1.2.5 Communication after cardiopulmonary resuscitation

Participants also spoke about the importance of communicating with the family especially after CPR, regardless of the outcome for their loved one. Communication after CPR helps the preparation of the family for the outcome of the CPR process.

" ..it is important to provide them [family] with information especially if it is an unsuccessful resuscitation" (Participant 5)

"...after the unsuccesfol resuscitation …we will usually talk to them nicely "(Participant 7)

4.4.2 Theme 2: Benefits and challenges of family presence during CPR

Implementing or having changes in healthcare practice has its advantages and disadvantages. The participants spoke about the benefits as well as the challenges that influence the practice of having family present during CPR situations. The benefits, however, outweighs the challenges when having the family present during CPR. There is benefits for the patient's family as well as the healthcare professional when the family is present during the CPR process. Challenges to this practice are related to the patients' family; healthcare professional as well as the emergency department as the operational

Category 2.1: Benefits of the practice of family presence during CPR

The participants identified the benefits to the practice of family presents during CPR for the patient, the family, as well as the medical officers and registered nurses were:

Code 2.1.1 Family benefits when present during CPR

Especially when the outcome is death, the family bond can be enhanced making the mourning process more bearable.

"...if it will help the family to accept death and with the grieving process, by all means, let them stand there and be part of the resus process" (Participant 2).

"...I think it will help the family with the grieving process and to accept the death of the loved one" (Participant 7).

"...it is better for them to moarn..... and for them to see what is happening to the loved one, ... there is a certain degree of peace, that everything was done for their family member" (Participant 8)

It also gives the family the opportunity to find peace and be at peace when they get the opportunity to be present during the last moments of their loved one.

"…so that the family can be at peace with what is happening with the patient " (Participant 2).

"…that family may feel that they were there with the last moments of their loved one and that they could see what the resus team has done, that the family can be assured and accept the outcome and know that the resus team has done everything to save the life of their loved one" (Participant 5).

Code 2.1.2 Benefits of family presence for medical officers and nursing professionals

Participants spoke about the rewarding feeling of allowing the family to be part of the CPR process. Therefore, it would build stronger relationships with the communities.

> *"...there will be a better understanding between the hospital and the communities "* (Participant 6).

> *"[S]ometimes it is just beter for families to see that you have done your best "* (Participant 8).

Category 2.2: Challenges with family presence during CPR practiced

The challenges that were identified during the data collection phase, pose a risk for all the key role-players as well as for the implementation of a practice of family presence.

Code 2.2.1 Family challenges when being present during CPR

One participant spoke of the challenge of secondary trauma that the family can experience with their loved one suffering an emergency. This trauma is compounded when they see and hear a lot of different noises and people running around.

> *"[I] think it is an overwhelming experience for them firstly to be there, and then to be surrounded by monitors going off everytime .... then there is lots of people talking to each other "* (Participant 2).

> *"...think it is traunatic for them to be there and to witness the resuscitation, which causes a secondary traumatic experience for the family aswel"* (Participant 5).

Code 2.2.2 Medical officers and nursing professionals' challenges with family presence during CPR

Participants also spoke of the challenges they experience. They might have difficulty in determining how the family would react to the outcome for their loved one and how to be there for the family at that point. They will know that the family is there watching them, how they are performing CPR. The family also needs to be updated regarding the condition of their loved one. Sometimes the challenges which the resuscitation team face is that there is not always someone who can answer their questions and give them all the information. It is not always possible to be supportive because of staff shortages. However, the family still needs someone to speak to them and answer everything they want to know. Family presence during CPR can also put stress on the resuscitation team, especially if some medical officers and registered nurses are inexperienced and when the family wants to witness the resuscitation process. Stress to the resuscitation team can also be because they know that people are watching them, and might judge how they perform during the CPR process.

"….so you give your all here, but in the back of your mind the family is also in the background watching you, so it is difficult sometimes" (Participants 1)

"…underlying stress …can put you at risk for medical-legal situations" (Participants 5)

Code 2.2.3 4.4.2.5 Emergency department's challenges when family presence during CPR

The environment for activities in the emergency department during CPR are not ideal for family presences. Participants' spoke of the work area that can sometimes be too small to accommodate the family, especially if there are multiple trauma cases. Participants also mentioned that although family would be provided the option, there are still factors that will make it impossible for family to be part of the CPR process.

"If you are saying that there is a patient with a penetrating chest wound and you need to open the patient's chest, then you need space to work, you need expertise, you need a lot of doctors and nurses to work…in limited space" (Participant 7)

"[O]ur resus unit accommodates only 4 beds and sometimes whenever a patient need specialist treatment like paediatrics, surgical and medical treatment then you need space with all the specialists and consultants need to see the patients" (Participants 10)

4.4.3 Theme 3: Family's choice and reactions

The choice of the family to be present when and where, as well as their reaction on the news of the status of the patient on top of the CPR; play an important role in allowing the family present during the CPR process.

Category 3.1 Choices of the family

It is important to note, that although choice to be present can be provided by the healthcare professionals, it is still the family's decision to be present during the CPR process or not. Their reactions will be elicited accordingly.

Code 3.1.1 Family's options during the CPR process

Participants mentioned the importance of providing the option to the family for them to make the choice of whether to be part of the CPR process or not.

"…if you are not going to involve them, and you are just going to tell them that the outcome appers to be bad and you are not going to provide them the option nie and when you go to them and say that it is done, it will cause a heartbreak to them" (Participant 2).

"…at least if they want to sten there and or if they want to leave or however they want to deal with the situation, they were provided the opportunity to be present or if they do not want to be present " (Participant 4).

Code 3.1.2 Family preferences during the CPR process

Another aspect that the participants spoke of was that is was always the family's choice; the option just had to be provided.

> *"...so it still remain the choice of the family, it is open to them, they can decide of they want to be present or not "* (Participant 1).

> *"Some people just chose not to be present, maybe the experiencecan be traumatic for them"* (Participant 8).

Code 3.1.3 Family decision during the CPR process

Regardless of the option that needs to be offered to the family, the decision of the family must always be respected, whether they decide to stay or to leave the room or do not want to witness it at all.

> *"...then there are those who says 'okay' they have seen enough they will rather go outside and we can let them know what is happening*" (Participant 2).

> *"Sometimes people prefer to stand there and stare and watch everything"* (Participant 8).

Category 3.2: Reactions of the family

The reaction of the family are an element and concept to consider for healthcare professionals when decisions to allow the family to be present or not. Furthermore, it will guide the healthcare professional to the extent of support to be given to the family. The family has various emotional reactions regardless of whether they are present or not. They may experience shock or denial; they are sometimes hysterical in their disbelief of what is happening, or they express resentfulness or ideally rational.

Code 3.2.1 Rational

Participants mentioned that some family member' reactions are very rational when in an unexpected family crisis. The family can be quiet, calm and very peaceful during the CPR process.

> *"Other people deel with it very quiet, they only sit there because they are socked "* (Participant 4).

> *"[J]ou get the guy and the family who is waking up and done in the passage and thenyou get the guy ..... who is still and says thankyou"* (Participant 5).

> *"...it depends on how calm and rational the family is about the situation"* (Participant 8).

Code 3.2.2 Hysterical

Family members can also act hysterically towards each other and throw themselves on the floor.

> *"...so for my it is when they get hysterical ..... then you want to hold them close, but sometimes it is impossible"* (Participant 1).

> *"...and obviously the family is hysterical, because they do not know what happend"* (Participant 6).

Code 3.2.3 Resentful

Participants mentioned that family can feel resentment, more because they feel guilty for not responding earlier to the pasient's emergensy. Resentment can also be experienced because the option to be present was not provided to the family.

> *"…I just feel that there are that contentment, that something was done to their*
>
> *loved one. They saw that everything was done whereas they would have felt*
>
> *resentment that they were not provided with the opportunity to see" (Participant 8).*

> *"...that they could see that everything was done for the baby and i also think that with the grieving process that she will not have that feelings of guilt , some mothers do have that resentment and feeling of guilt. That she can see that she brought the child in and that immediate attention were given to her child"* (Participant 9).

Code 3.2.4 Shocked

Participants mentioned that family members can be in shock and denial because of the resuscitation process and can then misinterpret things. Furthermore, the family might already experience shock inside the resuscitation room when seeing what is done to their family member.

> *"[U]sually the family are in any case shocked, because the do not know what happened or what is going on. This is a new experience for them as a family. They just stand there and have the expresion of shock on they face "* (Participant 1).

> *"[I] think it is an overwhelming experience[shocked] for them firstly to be there, and to be surrounded by monitors going off every time.....then there is a lot of people talking to each other" (Particiant 2).*

4.4.4 Theme 4: Type of CPR case

The type of emergency cases who are admitted to the unit is influential in the decision to have family present during CPR or not. Thus the prognosis of the patient also plays a role in the decision to allow family to be present during CPR process.

Category 4.1: Prognosis

Participants mentioned there is a difference between CPR of a chronic patient and CPR of a trauma patient. The participants also spoke about unusual exposure to family members in a complicated resuscitation event. The diagnosis and the intensity of the scenario have an impact on the prognosis of the patient towhom the CPR is done.

Code 4.1.1 Diagnosis

The diagnosis of the patient informs the active activities surrounding the CPR process for the patient

> *"...especially if the resuscitation was not expected by the family, especially in the case of a trauma patient, and you tell the family that the patient did not make it then this is ware they throw themselves on the fall and screem in disbelief "* (Participant 2).

> *"...how i experience it, is that the resuscitation of a child is more traumatic especially for the parents as well as the resuscitation of a young person...busy with active resuscitation, and you know that the patient is not going to make it" (Participant 8).*

Code 4.1.2 Scenario (case) intensity

The intensity or type of resuscitation is another factor to be considered when the family is provided the option to be present during CPR. The consultant on call has the discretionary power to decide whether it would be beneficial for the family to witness the CPR. Partcipants spoke about the different cases of emergency presenting and the difficulty to determin how the family would react to the different scenarios.

> *"[J]a, it is very important to go and look at the type of resuscitation it is, what the factors plays a rolle in the varias types of scenarios"* (Participant 7).

> *"...some people can handle blood and vomitus and some cannot handle blood. So then in that instance, it would not be advisable to expose people to that kind of scenarios, it depends on the type of situation and scenario" (Participant 10)*

Category 4.2 : Age of patient

Participants mentioned that the age of the patient also adds to the choice to provide the option for the family to be part of the CPR process. When children are resuscitated, then it would be strongly advised for the parents to be involved. With older patients, the family would know beforehand the status of the patient, but they would only be offered the option.

Code 4.2.1 Paediatrics

Participants mentioned that, especially with pediatric cases, parents of the patient must be involved. They would ask the parents to be part of the process to have closure. Participants accommodate the

parents of children to be present during CPR. Participants seem to be more engaged with the family when it is an infant being resuscitated.

> *"a baby was resussed and the parents requested to be present and the father were there the hole time. It is good thing to know that he was there and he saw that everything was done for the kid "* (Participant 1).

> *"...that they[parents] can see what has been done for the baby and i think with the grieving process it will help for mothers not have a feeling of guilt...That she can see that she brought the child in and immediate attention was given to the child' (Participant 9).*

Older patients

Participants mentioned that especially with older patients the family tend to be aware of the status of their loved one. It is still sad and difficult to deal with the news of CPR and outcome.

> *"[I]f it is the old lady who comes from home with the ambulance and the ambulance personnel is busy with active resuscitation , then we normally prolang the resuscitation for the family to know if they do want to see the process, so that they cannot say but now one gave them the opportunity to see "* (Participant 2).

> *"Sometimes it is elderly patients who some chronic illness where the family is aware that the patient is sick or was at risk of worsening the patient's condition" (Participant 10).*

4.4.5 Theme 5: Professional interactions and skills

It is important to have the necessary skills to be professional in serving in the family as well as within the resuscitation team. Participants indicated that professional engagement facilitates a smooth CPR process and relationship with family.

Category 5.1: Interactions of professional workers during the resuscitation process

Participants spoke about the necessity to be professional towards the colleagues and family during CPR as well as to have the skills to accommodate the family and the other departments with whom they work. Teamwork, being empathic and sympathetic and performing duties professionally is a must to be engaged during the practice of family presence during CPR.

Code 5.1.1 Teamwork

Participants indicated that when teamwork is at its best, the family relationship is good. Some participants also indicate there need for a well-functioned team. A few participants briefing to make the team more responsive to the needs of the family.

> *"…few hands, but if everyone works together effectively as a team.." (Participant 1)*

"The resus team should mork like a well-functioning machine" (Participant 10)

Code 5.1.2 Empathy and sympathy

The participants talked about personnel's interaction with the family experiencing the crisis. Medical staff is expected to process everything from the family's perspective and what they as family members would have wanted if they were in such a position.

"...u must really have that empathy and sympathy with the family but it is not always present" (Participant 1).

"One must have empathy for what families prefer" (Participant 2)

Code 5.1.3 Professonal duty

The partcipants indicated that it is their professional duty to be professional and to serve thos who are in need.

"….on our part to stay calm and not respond to their reactions but rather just to comfort and calm then [being professional]" (Participant7)

"….around the service they have to provide to this patient who needs to be helped now…." (Participant 9)

Category 5.2: Skills of the professional workers during the resuscitation process

Participants mentioned that, as the resuscitation team, they must have the skills to save the lives of those who are experiencing life threatening emergencies and to take the family through the process. It is up to the discretion of the senior doctor to decide whether to let the family be present or not.

Code 5.2.1 Decision-making

"(T)he senior healthcare provider must use his/her discresion" (Particiapnt 9)

"[healthcare professional] decide who can be present as a family member and who can bot" (Participant 10

Code 5.2.2 Being an advocate

Participants also indicated that the family require professional workers to look out for their interest and propose for them to be present. Furthermore, being an advocate for family involvement in the CPR process knowing the family may benefit.

"…..where the family wants to bome in (CPR room), if you almost propose it to t them" (Participant 2)

"…to make them involve…to say this is what we do…bring some understandind (Participant 8)

4.4.5.5 Collaboration

Participants also mentioned the fact that teamwork is the best way to have a successful resuscitation. They emphasized the importance of effective team approach and cooperating with each other, as well as with the different departments

> *"[U]sually if there is a resuscitation, then we sent a doctor to the family to get information about the patient as well as to inform the family that they can be part and see what every one is doing during the process "* (Participant 2).

> *"[W]e are working good together as a team, we are functioning as well oiled machine"* (Participant 4).

4.4.5.6 Provide comfort

Participants mentioned how important it is to providing comfort and support the family, whilst not becoming carried away or become emotionally involved with situations. Family members wants the healthcare professional to be there for them so they can be at ease with the CPR and the outcome.

"support….assist…comfort….courage and expain the process" (Participant 3)

"…….just to be there and console them" (Participant 7)

4.5 SUMMARY

This chapter presented the findings on the perceptions of medical officers and registered nurses about the practice of family presence during CPR at the emergency centre of a secondary hospital in the province of the Western Cape in South Africa. The study revealed that the medical and nursing personnel mostly found it beneficial for the healthcare provider, the patient as well as the family if such a practice will be implemented. The interviews also revealed that there are certain factors to consider with this practice such sufficient information and communication, and the benefits and challenges to the family, the medical and nursing personnel as well as the department. The prognosis status of the patient, the types of CPR cases and the intensity of the scenarios are all factors to consider in allowing family practice. Professional interactions and the skills of the

resuscitation team are also considered key to the implementation of the practice of family presence during CPR situations.

Surprisingly, the feedback of most of the participants was positive and they indicated that there is a need for a practice of family presence at CPR. However, there were participants who were hesitant and voiced their concerns regarding such a practice with the challenges identified. There were also various factors mentioned that have an impact on the decisions to or to provide family the option to be present or not.

In essence, most participants were very positive towards this practice and would consider implementing a practice such as this in clinical practice. In chapter 5, the findings of the study in relation to the literature will be discussed. A conclusion will follow and recommendations will be offered.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In chapter 1, the rationale and objectives of the study were provided while chapter 2 reflects othe literature review. In chapter 3, the research methodology was discussed and in chapter 4, the findings of the study were presented. This chapter contains the conclusions based on the findings of the study. Recommendations based on perceptions of medical officers and registered nurses about family presence will be made.

The main purpose of this research study was to explore and describe the perceptions of medical officers and registered nurses about family presence during CPR. The participants were four medical officers and six nursing sisters who are managing CPR in the emergency unit of a secondary provincial hospital in the Boland region of the Western Cape province.

5.2 MAJOR FINDINGS DISCUSSION

It is clear from the interviews that the majority of the medical officers and nursing professionals in the emergency unit of the secondary hospital of the Boland region in the province of the Western Cape welcome the practice of family presence during CPR. There was an exception with one participant who indicated that the family should only stand there and watch so that they will not be a nuisance.

The purpose of this study was to explore and describe the perceptions of medical officers and nursing sister about family presence during CPR in the e mergency centre of a secondary hospital in the province of the Western Cape in South Africa. The goal of this study was to gain insight from medical officers and nursing sister' perceptions about the practice of family presence during CPR at the emergency centre. The major findings generated from the interviews and utilizing content analysis will be discussed with support from relevant literature.

5.2.1 Research objective: Exploration and description of the perceptions of medical officers and nursing sisters about the practice of family presence during cardiopulmonary resuscitation. The discussion of findings emerged from the studie will follow

5.2.1.1 Information communication

Good communication and giving accurate information in an understandable manner so that the family can understand, will minimize medical legal risk to which the resuscitation team might be exposed. The same was said in a study done by Tomlinson et al. (2010: 48), that the risk for medico-legal implications would be minimized if the family is guided in a manner where they would understand the situation. To follow will be the discussion about information that emerged from the data analysis.

5.2.1.1.1 Information

Participants said that it is important to keep the appropriate family members informed, especially the immediate family. However, one must be selective as to which family members should be involved in the resuscitation by providing information about what to expect. Kingsnorth, O 'Connell, Guzetta, Edens, Atabaki, Mecherikunnel & Brown (2010: 118) agree that immediate family should have preference to be allowed in the resuscitation event. Participants in the current study also mentioned that accurate information provided in an understandable manner is important to alleviate agitation and to decrease the stress that the family might experience. The same results was illustrated in studies done by Porter, Cooper & Sellick (2014: 71) and Madden & Condon (2007: 434).

Medical knowledge must be made available to the family in an understandable manner, on their level, as well as in the language with which they feel comfortable. The resuscitation team member who is allocated to the family must take the family through the whole process, step by step so that they can understand why certain procedures are done. Tomlinson et al., (2010: 48) also explained that the spokeperson must briefly explain the resuscitative process in an understandable manner.

The importance of accurate information provision regarding the patient's condition and prognosis to the family was also a prominent factor that featured in the interviews in the current study. A study done by Brasel et al., (2016: 1438, illustrated that the spokeperson, needs to take the family through the resuscitation process. Participants mentioned that the family needs to receive live updates regarding the resuscitation itself, or the condition of the patient, whether they are present during CPR or not. It was said that it is also important for the family to receive information in an understandable manner to comprehend the seriousness of the patient's condition. Tomlinson et al., (2010: 48) and Chapman et al., (2013: 22).

Patients who are receiving emergency care has the right to confidentiality, which means that no confidential information be disclosed by the doctor. Confidentiality in medicine serves two purposes ss described by Kling (2010: 196). It ensures respect for the patient's privacy, and acknowledges the patient's feelings of vulnerability. It also improves the level of healthcare. However, the Health Professions Council in South Africa (HPCSA, 2015) states that it is possible to disclose confidential information without the patient's consent if the risk of harm outweighs the patient's right to confidentiality (HPCSA, 2015).

The amount of confidential information disclosed to family was one of the aspects that were mentioned. This links with privacy of the patient, which can easily be invaded. It was also said that it must be at the discretion of the medical officers to provide the necessary information to the family and according to what the family understands. Critchell and Marik (2007: 313) mentioned in their study that confidentiality can complicat the decision to allow family during CPR. However, it is still necessary to keep the family informed, as they have the critical decision in this period, such as discontinouing CPR, artificitul ventilation.

Privacy is of utmost importance, especially in the emergency centre. People in general, especially family members, tend to walk in on consultations, when procedures are being performed without even asking or saying for whom they are looking. Critchell and Marik (2007: 313) mentioned that the results of this are the possibility that medical information not previously known to family can lead to chaos. To be involved in resuscitation, where the family hears formation that was not known to them is also invasion of the patient's privacy. This is also a major concern for the participants in this study and aligned with an American study done by Mian et al. (2007: 54) who illustrated that invasion of privacy was an important aspect to consider.

5.2.1.1.2 Communication

Communication was seen as an important factor during the interviews. It was mentioned in the interviews that communication with one person to the family during the resuscitation is of utmost importance. Therefore, it is important that a knowledgeable person, preferably a member of the resuscitation team, talk to the family before they enter the resuscitation room and inform them what to expect once they are in the room. In a study done by Le Goff (2012: 16) the participants mentioned that it would be beneficial for the family to have a member of the resuscitation team with them to explain everything. Gordon et al. (2011: 765) also mentioned that a senior member of the resuscitation team should be allocated to communicate with the family.

5.2.2 Benefits and chellenges for family presence during cardiopulmonary resuscitation.

Benefits of the family being present during CPR outweighs the challenges

5.2.2.1 Benefits for family with the practice of family presence during CPR

Bereavement is a process has the potential to create family bonds and enhance family connectedness, if the process is handled well. In the situation of bereavement where the family expects loss, breaking the news to the family might be a little easier and assist with closure that everything was done for the patient. In a study done by Brasel et al. (2016: 1438), it was explained that the presence of family members would help with this grieving process and family connectedness. The same was said in a study done by Porter et al., (2014:71) that the presence of family would facilitates closure and family bonding.

5.2.2.2 Benefits for medical officers and nursing professionals with the practice of family presence during CPR.

Family presence during CPR can ensures a good relationship between families and the medical team. It helps the family understand that everything was done to bring the patient back. The same was mentioned in the studies done by Brasel et al., (2016: 1439) and Critchell and Marik (2007: 312). It also helps the family to grasp the reality of death. Family presence helps alleviate feelings of agitation and frustration the family might experience. The family is able to go through the grieving process and get closure. Davidson et al. (2011: 336) describe the same benefits in their study.

5.2.2.3 Family challeges during the practice of family presence during CPR

Secondary trauma was also an aspect that was talked about in the current study. With the traumatic feelings the family is already experiencing, to witness some of the procedures in the resuscitation room can have traumatic effects on the family. Studies by Koberich et al. (2017: 31) and Asencio-Gutiarez and Reguera-Burgos (2017: 55) simiraly found a family can find it psychologically disturbing to see the visual images of CPR and it can lead to that family becoming physically and emotionally abusive towards the resuscitation team. The same is illustrated in the study by Gordon et al., (2011: 766). It can be very difficult at times to evaluate the family's mental state and personality in the different scenarios. Kingsnorth et al., (2010: 118) also found that it is difficult to evaluate the emotional state and wellbeing of family present. It is also difficult to communicate with family because it might be difficult for the healthcare provider to assess and evaluate how families would handle the situation. Studies done by Tomlinson et al., (2010: 47) and Mian et al., (2007: 54) which illustrated the same results. Fears that families can become so emotional that it can lead to the prolongation of the resuscitation process, was reportad in a study done by Powers (2017: 25).

5.2.2.4 Challenges for medical officers and registerd nurses with the practice of family presence during CPR

When the resuscitation team are confronted with the CPR situation the immediate responsibility of the resuscitation team is to attend to the patient in need. Therefore their attention is split durig CPR. It is difficult to determine the behaviour pattern of the family beforehand. Kingsnorth et al., (2014: 118) found that the family's responses must be assessed before the option is provided. Therefore, ideally a spokesperson should be available, who can accommodate the family and who can attend to such a family member who cannot handle the situation that well (Brasel et al., 2016:1439). Contrarey to these findings, Oczkowski et al. (2015), suggests that the family presence during resuscitation does not affect resuscitation outcomes and improves family psychological outcomes.

5.2.2.5 Challenges for medical officers and nursing professionals during a practice of family present during CPR

The medical-legal implications of which the healthcare provider must be aware was mentioned by participants. Results in the study done by Critchell and Marik (2007: 413) potrayed an increased risk of liability and litigation feared by participants.The participants spoke about the atmosphere in the room which can can lead to many mistakes and aspects that can go wrong. Studies done by Sak-Dankosky et al., (2017: 3) and Duran et al., (2007: 44) whom found the family can wrongly interpret those mistakes or the procedures of the medical team. The family can then easily say that it is because of certain actions taken by the doctor or nurse that led to the death of their loved one. This challenge was also mentioned in a study done by Tomlinson et al. (2010: 47).

5.2.2.6 Challenges of emergency department when practising family presenc during CPR

The shortage of doctors continues to be a problem in South Africa public healthcare Staff shortages can hinder the implementation of family presence of CPR. The same was mentioned in the studies

done by Critchell and Marik (2007: 414), Davidson et al., (2011: 337) and Gordon et al., (2011:765). Sometimes it is very difficult to provide the family the option of being present, with a shortage of staff to attend to them too and it usually at the discretion of the most senior healthcare provider to allow the family to be present or to ask them to wait outside the patient's room. Gordon et al. (2011: 765), confirmed that the medical officer who is in charge of the resuscitation must decide whether the family may be present or not.

Another aspect that was mentioned by participants in the current study was the fact that CPR situations could get brutal in nature with bodily fluids, blood and vomitus around the patient. With specialists and doctors surrounding the patient, it would make it impossible for family to witness any of the procedures. In addition, with so many other doctors present, the resuscitation room would be too small to accommodate the family as well. Resources would be another aspect that could hinder the implementation of such a practice (Tomlinson et al., 2010: 46). Such resources include funding to employ a person and for that person to receive the training to acquire specific skills to accommodate the family of the patient in an emergency. Gordon et al., (2011: 766) confirmed specialised skills is necessary for such a person to accommodate the family.

5.2.4 Family's choices and reactions before, during and after cardiopulmonary resuscitation

5.2.4.1 Family's choices determine the action of being present or not during CPR

According to participants it is ultimaly the choice of the family to be present during CPR. Gordon et al., (2011: 765) mentioned that is not mandatory for family to be present during CPR, but that it is important that the resuscitation must provide them with the option to be involved. However, if the family decides to be present initially and decides afterwards that they probably have seen enough, they are also allowed to leave the resuscitation room. This was also mentioned in a study done by Mian et al., (2007: 55) and Brasel et al., (2016: 1439).

5.2.4.2 Family's reactions determine the action of being present during CPR

It can be difficult sometimes to evaluate the different families in certain scenarios. Sometimes it can become difficult for staff to communicate with families because they cannot predict or determine how people will react when you give them information or when they witness procedures. Subsequently, medical personnel fear that a family member may demand care that is not in the best interests of the patient. Families could also become so emotional that it would lead to the prolongation of the resuscitative efforts (Powers, 2017: 25).

Koberich et al. (2010: 31) furthermore mentioned that families could become physically and verbally abusive, whereas others also claimed that families can either faint, vomit, scream or disturb the other patients (Powers, 2017: 25).

5.2.5 The type of cardiopulmonary resuscitation case allow the family to be present during CPR

Participants clarified that the prognosis of a patient as well as the types of CPR cases would determine if the healthcare providers would allow the family to be present or not. Gordon et al., (2011: 765) mentioned this aspect.

5.2.5.1 Prognosis of the patient determine the decision of allowing the family to be prent during CPR

Allowing the family in the resuscitation room depends on the acuity of the patient's condition, whether it is a chronic patient or trauma-based case. Tomlinson et al., (2010: 47) confirm these findings. The decision to allow family present will be made accordingly, because there is a difference between CPR of a chronic patient and CPR of a trauma patient. Similar reported findings mentioned Gordon et al., (2011: 766). Participants spoke of the fact that they would more likely perform CPR longer on a trauma patient in an attempt to save the person's life, than for a chronic patient. The same findings were stated in a study done by Tomlinson et al., (2010: 47).

5.2.5.2 Age of the patient determin the decision of allowing the family to be present during CPR

The age of the patient must be considered when it comes to emergency situations. Participants felt that, although the choice resides with the family, they would consider and advocate for their presence more so when it is a pediatric emergency (Kingsnorth et al., 2010: 116) stated that parents usually are allowed to be present during a CPR event.

5.2.6 Professionals interactions influences the facilitation of the practice of family presence during CPR

The processionals interactions and skills are essential to manage the practice of family presence during cardiopulmonary resuscitation. The healthcare personnel must acquire the skills to assist in managing such a practice. To perform resuscitation regularly requires a dedicated team to render an adequet service, and allow the family to be involved. Gordon et al., (2011: 765) and Brasel et al., 2016: 1439) illustrated the importance of dedicated team to perform CPR. Healthcare personnel need to have the necessary skills to recognise the patient's health condition and to act accordingly. A team needs to have a knowledgeable spokesperson to accommodate the family and still be part of the resuscitation team who attempts to save a patient's life. The study done by Porter et al(2014: 70) illustrated the same conclusion.

Another important aspect that was mentioned was that the team must work cohesively as a team. Every person on the team should know what s/he must do and what his/her respective roles are during resuscitation. Similar results were shown in the study done by Hoyer et al., (92009: 244) and Plagisou et al., (2016: 151). The resuscitation team member who is allocated to the family must

provide an overview and take the family through the process of how the team operates as well as why everyone in the team has a specific role in CPR. Jabre et al., (2013: 1015) had illustrated that effective teamwork in the resuscitation would be beneficial to all those involved.

5.2.5.2 Professional skills influence the facilitation of the practice of family present during CPR

Participants mentioned that decision-making is pivotal in terms of when and in what circumstances family would be allowed to be present during CPR. It is also an acquired skill to save a patient's life. Similar results were illustrated in studies done by Passali et al., (2011: 365) and Plagisou et al., (2016: 149) to advocate for acquiring specific CPR skills to save lives of patients. Hoyer et al., (2009: 241) also mentioned that participants felt that it is a professional duty to advocate that family should be present, especially with pediatric emergency cases. Porter et al. (2014: 71) describes it as a part of professionalism when healthcare professionals have to make decisions about family presence during a resuscitative event.

The family support person has an integral role. Therefore, the focus of the family support person must be on the family with no active role in patient care. Similar results were shown by Kingsnorth et al., (2010: 118) that the family support person needs to attend to the family and have no active role in the resuscitation. Family presence would increase family connectedness and bonding during and after the resuscitation event. The family would feel a sense of emotional involvement while their loved one was receiving CPR. The same was said in studies done by Koberich et al., (2010: 245) and Powers (2014: 25). To see and touch the patient, would establish an emotional connection between the family and patient. A study done by Hund and Pang (2010: 60), indicated that there is an obligation to provide love and support, and that it was the most important experience fot the family.

5.3 LIMITATIONS OF THE STUDY

A limitation for this study was that the study was conducted in only one emergency centre in the province of the Western Cape in South Africa. A further limitation could be that only the healthcare providers who were directly invoved with resuscitation between the 17 Augustus and 21 September 2018 were eligible for the study.

5.4 CONCLUSIONS

Relevant findings from this study are the importance of communication to and from the family. Supplying information adds value to the CPR process and allows families to be part of the process. The benefits of presence during CPR are establishing of good relationships with the family, and

alleviating the grieving process. The challenges posed to the implementation of such a practice includes healthcare personnel's attention being split between the family and the patient while performing CPR, the shortage of personnel and the lack of room to accommodate the family.

Other findings show that the types of CPR cases as well as the intensity of CPR scenarios will influence the decision to allow the family during resuscitation (Kingsnorth et al., 2010: 116; Gordon et al., 2011: 766 & Tomlinson et al., 2010: 47). The prognosis and age of patients will also influence that decision. The professional interactions of the resuscitation team as well as their professional skills to have empathy and sympathy were also mentioned as factors to allowing presens at CPR.

5.5 RECOMMENDATIONS

Based on the findings of the research study, the following recommendations are made to the management and emergency department in order to improve and facilitate understanding of the practice about family presence during CPR at the hospital of study:

- Collogial awareness campaigns regarding family presence during CPR
- Develop a CPR protocol allowing family presence during CPR where all parties are involved
- Collogiality of all members of the CPR team, and especially the management team, for successful implementation
- Monitoring and addressing any feedback related to barriers to the implementation of the family presence during CPR protocol
- Continuous education and training regarding CPR
- Assistance from management related to human resources to facilitate the family presence during CPR practice
- Considering of healthcare spaces in designing emergency care units.

Furthermore, the researcher provides recommendations specific to each theme.

5.5.1 Information communication

- The emergency unit secretary needs to assist in gathering patient information utilising a standardised document.
- The emergency unit need to have mediators available at the beginning of the CPR process with back-up staff made available form management's side.
- Workshops and skills training need to be made available about conveying informed messages to family members.

5.5.2 Benefits and challenges of family presence

- All healthcare practitioners must
    - be made aware of the benefits of the practice of family presence during CPR

  - receive updated training regarding support to family during CPR
  - receive updated healthcare provider CPR training.
- Management needs to address staff shortages and small workspaces.

5.5.3 Family's choices and reactions

- Public awareness campaigns need to be run regarding family presence during CPR.
- Healthcare personnel need to provide useful information regarding the patient's condition to families so that they can make infomed decisions.
- Family must also be accompanied to the sanctuary of the hospital to have a quiet moment if death was imminent.
- Healthcare staff need education and training on how to convey bad news to the family and how to manage family behavior thereafter.

5.5.4 Type of cardiopulmonary resuscitation

- A senior consultant needs to decide whether a family could be present due to the prognosis and high intensity of the CPR case.
- Families, who insist on being present, should be made aware of the implications of witnessing high intensity CPR cases.

5.5.5 Professional interactions and skills

- Roles regarding the practice of family presence during CPR should be clarified.
- Continued skills development training regarding decision-making, ethical dilemmas, advocacy, collaboration and family support need to be made available.

5.5.6 Future research

The following areas for future research are proposed:

- The presence of family members during CPR from the patient and family's perspectives.
- The perspective of the patient, who has been successfully resuscitated, on family presence during resuscitation.
- The effect of the parents' presence on the resuscitation of their children.
- Communities' perspectives on family presence during CPR.

5.6 DISSEMINATION

These research results will be shared with the management of the study hospital as well as the management of the emergency centre and Hospital Facility Board. The expectation is that some of the recommendations made can be implemented in the emergency centre to improve family-centred care. The study findings will be disseminated through the publishing of articles in an attempt to

contribute to the limited body of knowledge available on the concept under study. The study will also be reported to the Western Cape Provincial Department of Health.

Results will also be submitted as an article for publication to a peer-reviewed journal in addition to it being presented at an academic conference.

5.7 CONCLUSION

The research study highlighted that the perceptions of medical officers and registered professionals about family presence during CPR were mixed. In essence, most participants had positive perceptions. The study also highlighted the need for a practice such as this. It is evident that the patient, the family as well as the healthcare provider would benefit from this. Challenges such as staff shortages, lack of room to accommodate the family, and secondary trauma the family might experience were highlighted in this and various other studies. The risks of medical personnel having their attention split between the medical team and family was also highlighted in this study. The benefits are the provision of emotional support for the family, the relationship that could be enhanced between the family and the medical team, and the alleviation of the bereavement process. Other factors that would influence the decision to allow family to be present are the prognosis status of the patient, the types of CPR cases as well as the intensity of the CPR cases. The family's choice to be present and their reaction to the CPR need to be considered.

The resuscitation team's professional interactions with the family include showing empathy and sympathy to the family. Effective communication and the importance of information are also some of the factors that were evident in this research study.

However, the aspects not mentioned in the interviews were:

- The fact that participants did not mention the need for education or training for them to help improve a practice such as this, while in various other research studies the importance of training or education was mentioned.
- Participants also never mentioned that the spokesperson for the family could be a chaplain who can accommodate to the family.
- Participants also did not mention the importance of patient preferences in case an emergency arises, what the patient would want.
- Participants also did not mention that they will not consider such a practice without a protocol, whereas in other international studies it was conveyed as an important aspect.
- What also was surprising for the researcher is that some of the participants of the current study mentioned that with paediatric emergency cases they feel those family members such as, the mother or father must be present. The option does not have to be provided to them.

The conclusions and recommendations for this study were discussed. Recommendations that might be considered before a practice such as this can be implemented were offered. Finally, this research underlines the value of involving the family in resuscitation whether it is paediatric or adult patients.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

Approved with Stipulations

New Application

29/03/2018

Project ID: 6480

HREC Reference #: S18/03/047

Title: Perceptions of nursing professionals and medical officers about family presence during CPR

Dear Miss Hanilene Russell,

The **Response to Modifications** received on 26/03/2018 07:12 was reviewed by members of the **Health Research Ethics Committee 2 (HREC2)** via Minimal Risk Review procedures on 29/03/2018 and was approved with stipulations.

Please note the following information about your approved research protocol**:**

Protocol Approval Period: 29**-Mar-2018 – 28-Mar-2019**.

The stipulations of your ethics approval are as follows:

1. Feedback comment 1: From the explanation provided it is still not clear why participants not exposed to a resuscitation should be part of the **inclusion** criteria. Do you perhaps mean that this should be an **exclusion** criteria?

2. Feedback comment 2: In the response to modifications letter you state: *'As the researcher is working as a registered nurse in this emergency setting and the relationship she have with the potential study participants, the fieldworker will do the bulk of the interviews. The researcher will do the interviews with participants who is relatively new to the emergency unit and who does not know the primary researcher all that well.*' This information is not in the protocol and must be included in the final protocol. Will it not be better for this fieldworker to do all the interviews?
Consider the power dynamics between participants who are new in the emergency department and you as the researcher who is a senior professional nurse as stated in section 4 of the revised protocol.

3. Feedback comment 3: Consent form – the benefits described in the revised consent form may appear biased since it alludes that participants should change their clinical practice. You explained in the protocol that family members are not allowed to be present during CPR in the study context and therefore this statement may appear judgmental. Kindly revise this so that it is stated in a more tentative way e.g. that information may be used to inform guidelines with regards to family presence during CPR.

Please remember to use your **Project ID 6480**on any documents or correspondence with the HREC concerning your research protocol.

Please note that this decision will be ratified at the next HREC full committee meeting. HREC reserves the right to suspend approval and to request changes or clarifications from applicants. The coordinator will notify the applicant (and if applicable, the supervisor) of the changes or suspension within 1 day of receiving the notice of suspension from HREC. HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note you can submit your progress report through the online ethics application process, available at: https://apply.ethics.sun.ac.za and the application should be submitted to the Committee before the year has expired. Please see Forms and Instructions on our HREC website for guidance on how to submit a progress report.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website (www.sun.ac.za/healthresearchethics)

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Francis Masiye,

HREC Coordinator,

Health Research Ethics Committee 2 (HREC2).

National Health Research Ethics Council (NHREC) Registration Number:

REC-130408-012 (HREC1)·REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1)·IRB0005239 (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the World Medical Association (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects;the South African Department of Health (2006). Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa (2nd edition); as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes and Structures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Servic

Appendix 2: Appendix 2: Permission obtained from institutions / department of health

Western Cape Government
Health

Health impact assessment
Health research sub-directorate
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REFERENCE: WC_201804_011
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Tygerberg Hospital

Francie Van Zijl Drive

Parow Valley

Cape Town

7305

For attention: Ms Hanilene Russell

Re: Exploring the perceptions of nursing professionals and medical officers about family presence during cardiopulmonary resuscitation of a Secondary hospital, Western Cape.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following person to assist you with any further enquiries in accessing the following sites:

Paarl Hospital	**Dr Francois Van der Watt**	**021 860 2508**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

Appendix 3: Participant information leaflet and declaration of consent by participant and investigator

Title of the research study: Exploring the perceptions of medical officers and nursing professionals about family presence during cardiopulmonary resuscitation.

Reference number: S18/03/047

Principle Investigator: Ms Hanilene Russell

Address: Department of Nursing

Faculty of Medicine and health Sciences

Stellenbosch University

PO Box 241

Cape Town

8000

Contact Number: 021 9389823/9036

Dear participant

My name is Hanilene Russell and I am a student in the Master of Nursing programme at Stellenbosch University. I would like to invite you to partake in a research study that aims to explore and describe the perceptions of medical officers and nursing professionals about the practice of family presence during cardiopulmonary resuscitation at the secondary provincial hospital.

Please take some time to read the information regarding the study, which will explain the details of this study. If you should require any clarification or information of any aspect of the study, do not hesitate to contact me or my supervisor.

Introduction and Purpose

The purpose of this research study is to explore and insight into the perception of the doctors and registered nurses. This research may significantly contribute to qualify patient care and add value clinical practice.

Procedure

Your participation in this study will be a face to face interview which will be more conversational in nature with a fieldworker in a private room or at a place convenient to you, where interview will be audio-recorded and field notes will be made. The interview will last approximately 45 minutes to one hour. You have been chosen to participate in this study because you fit the inclusion criteria of medical and nursing professionals and is therefore able to provide information about this topic.

Benefits

This information gained from this study may benefit you, perhaps the patient and the family members involved. Also, to address the issue of whether to allow family members to be present to be during resuscitation or not.

Voluntariness/ Withdrawal

The participation in this study is voluntarily and you are not obligated to take part. You can however withdraw from this study at any time without any penalties. It will also be discussed with the participant and consent will be obtained from the participant for information up till the point of withdrawal, to be used in this study.

Risks

We do not anticipate any risks for you. However, if you feel overwhelmed at any time, I could refer you to a counselling facility.

Confidentiality

The information that will be collected during this phase will be kept confidential at all times by using pseudonyms. I will safe-keep the recordings and the transcriptions. Therefore, the data will be stored in a safe place and only my supervisor and I will have access to your interview. The information from this may be published for research purposes, but your identity will be kept confidential.

Payments and Costs

There will be no costs involved in this study for you if you do take part. You will also not be paid to participate in this study, but refreshments will be provided to you before the interview.

Ethical Approval

This study has been approved by the Health Research Ethics Committee of Stellenbosch as well as the Western Cape Government of Health.

Questions

If you have any questions or queries about this study, you can contact me, Ms Hanilene Russell at cell: 0723931069. Thank you very much for your time and willingness to participate in this study. However, you can also contact the Health Research Ethics Committee on 021 9389207 if you have any complaints, comments or concerns regarding any aspect of this study or the principle researcher. You will also receive a copy of this information and consent form for your own records.

The above aspects have been discussed with the participants. My finding is that the participant understands the risks, benefits and obligations involved in this study.

I did / did not use an interpreter.

Signature…….. Date…….

Declaration by the participant

By signing below, I……. agree to participate in a research study entitled: Exploring the perceptions of medical officers and nursing professionals about family presence during cardiopulmonary resuscitation.

I declare that:

- I have read or had been read to me this information and consent form and it is written in a language with which I am comfortable and fluent.
- I have / had a chance to ask questions and my questions were adequately answered.
- I also understand that participation in this study is voluntary and I have not been forced to take part.

Signed at (place)…….on (date)……2018

…….. ……

Signature of participant Signature of witness

Appendix 4: <u>Interview guide</u>

Date: Place:

Interviewer: Interviewee:

1. How long have you been working in this emergency unit?

2. Tell me can you remember an incident where you were part of a resuscitation attempt and a family member present?

   Probes:

   - How did you feel?
   - Can you explain further?

3. As an emergency nursing or medical professional, how would you feel, if your patient is resuscitated and the family member(s) request to be present during the process?

   Probes:

   - Can you elaborate…..?
   - Why do you think so….?

4. How do you think this practice will affect family members if your hospital specifically starts to implement it?

   Probes:

   - Could you give me examples?
   - You mentioned….could you tell me more about that?

Appendix 5: **<u>Deelname informasie blad en toestemmingsvorm van deelnemer en navorser</u>**

Titel van navorsings studie: Eksplorasie van mediese beamptes en geregistreerde verpleegkundiges se persepsies oor die praktyk van die teenwoordigheid van familielede tydens kardiopulmonale resussitasie.

Verwysingsnommer: S18/ 03/ 047

Primêre Navorser: Mej Hanilene Russell

Adres: Departement van Verpleging

Fakulteit van medisyne en gesondheids wetenskappe

Universiteit van Stellenbosch

Posbus 241

Kaapstad

8000

Kontaknommer: 021 9389823/9036

Geagte Deelnemer

My naam is Hanilene Russell wat tans meesters in verpleegkunde studeer aan die Universiteit van Stellenbosch. Graag wil ek u uitnooi om deel te hê aan ‘n navorsingsstudie wat poog om insig te verkry oor die persepsies van mediese beamptes en geregistreerde verpleegkundiges rakende die praktyk van familielede wat teenwoordig is tydens kardiopulmonale resussitasie in die noodeenheid van die sekondere hospitaal. Neem asseblief u tyd om deur die informasie rakende die studie te lees wat ook al die besonderhede van die studie verduidelik.

<u>Inleiding en doel van die studie</u>

Die doel van die studie is om insig te kry oor die persepsies van mediese beamptes en geregistreerde verpleegjkundiges. Hierdie studie kan ook doeltreffend bydra tot kwaliteit pasientsorg en waarde voeg tot kliniese praktyk.

Proses

U deelname in hierdie navorsingstudie sal ‘n aangesig tot aangesig onderhoud wees, wat deur ‘n veldwerker gedoen sal word. Die onderhoud sal op band gerekordeer word en notas sal ook gemaak word. Die onderhoud sal ongeveer 45 minute tot ‘n uur duur. U word dus as deelnemer gekies om in hierdie studie deel te hê omdat u die kriteria pas van mediese en verpleeg professionele persone en kan ook insiggewende kennis oor hierdie onderwerp gee.

Voordele

Die inligting wat deur die studie verkry sal word, kan dalk u, die pasiënt en ook die familielede van die pasiënt bevoordeel. Die inligting kan ook dalk die onderwerp rakende die teenwoordigheid van familielede tydens kardiopulmonale resussitasie addresseer.

Vrywilligheid/ Onttrekking

U deelname aan hierdie studie is vrywillig en is u nie verplig om deel te hê nie. U kan ook op enige stadium van die studie onttrek sonder enige negatiewe nagevolge. Dit sal ook dus bespreek word met die deelnemer en toestemming sal ook van die deelnemer verkry word.

Risiko’s

Geen risiko’s word geantisipeer nie, maar as u op enige stadium oorweldig voel, kan u na ‘n beredingsfasiliteit verwys word.

Vertroulikheid

Die inligting wat gekollekteer gaan word gedurende die fase, sal ten alle tye streng vertroulik gehou word deur die gebruik van skuilname. Ek sal die

rekorderings van die onderhoude en ook transkripsies veilig bewaar. Dus, sal die data in ‘n veilige plek gestoor word en slegs die veldwerker, akademiese toesighouer en ek sal toegang hê tot die onderhoude. Daarvolgens, alle inligting wat verkry sal word van die studie, kan dalk gepubliseer word vir navorsingsdoeleindes, maar u identiteit sal vertroulik gehou word.

Betalings en Koste

Daar is ook geen koste betrokke in hierdie studie vir u indien u sou deel hê aan die studie. U sal ook geen vergoeding of betaling ontvang vir u deelname aan die studie nie, maar verversings sal aan u voorsien word voor die onderhoud sal plaasvind.

Etiese goedkeuring

Hierdie studie is goedgekeur deur die Gesondheids Navorsings Etiese Komittee van die Universiteit van Stellenbosch asook die Weskaapse Gesondheids Departement.

Vrae

Indien u enige vrae het rakende die studie, kan u my, Mej H J Russell kontak by 0723931069. Baie dankie vir u ty den ook bereidwilligheid om deel te hê aan die studie. U kan ook die Gesondheids Navorsings Komitee kontak by 021 9389207 indien u enige klagtes, kommentaar of kommerhede het rakende enige aspek van hierdie studie of die primêre navorser. U sal ook ‘n kopie van die inligting asook die toestemmingsvorm ontvang vir u eie rekord.

Die bogenoemde aspekte was bespreek met die deelnemers. My bevindinge is dat die deelnemer die risiko’s, die voordele en ook die verpligtinge betrokke by die studie verstaan.

Ek het/ het nie ‘n interpreteerder gebruik nie.

Handtekening……. Datum……

Verklaring van die deelnemer

Ek die ondertekende …… stem om deel te neem in die navorsingsstudie met die titel: Eksplorasie van persepsies van mediese beamptes en geregistreerde verpleegkundiges oor die teenwoordigheid van familielede tydens kardiopulmonale resussitasie.

Ek verklaar dat:

Ek het die inligting gelees/ was aan my voorgelees asook die toestemming en dit was geskryf in ‘n taal waarmee ek gemaklik was.

Ek het kans gekry om vrae te vra en die vrae was voldoende beatwoord.

Ek verstaan ook dat deelname in hierdie studie vrywillig is en was nie geforseer om deel te neem nie.

Teken by (plek)……op(datum)…….2018

Handtekening van deelnemer Handtekening van getuie

…….. ……..

Appendix 6: **<u>Onderhoudsgids vir die deelnemer</u>**

Datum: Plek:

Onderhoudvoerder: Deelnemer:

1) Hoe lank is u werksaam in hierdie noodeenheid?

2) Kan u ‘n insident onthou waar u dalk betrokke was tydens ‘n resussitasie aangeleentheid en die familielede was betrokke?

   Ondersoekvrae : Hoe het u gevoel?

   Kan u verder verduidelik?

3) As ‘n geregistreerde verpleegkundige of ‘n mediese beampte , hoe sal u voel as u pasiënt geresussiteer word en die familielede rig ‘n versoek om teenwoordig te wees?

   Ondersoekvrae: Kan u meer uitbrei…..?

   Hoekom dink/voel u so…?

4) Hoe sal u sê as hierdie praktyk geimplementeer word by die instansie, dit die familielede affekteer?

   Ondersoekvrae: Kan u dalk ‘n voorbeeld gee?

   U het genoem….. kan u my meer vertel van?

   NOTAS:

APPENDIX 7: **Transkripsie van onderhoud tussen veldwerker en deelnemer 2**

Veldwerker

More dokter, ek is marilynne ek is n veldwerker vir student Hanilene oor die eksplorasie van mediese beamptes en geregistreerde verplegkundige se persepsie oor die praktyk van die teenwoordigheid van familielede tydens kardiopulmonale resussitasie. Ek wil vir u inlig dat hierdie navorsings projek is goedgekeur deur die Universiteit van Stellenbosch, Mediese Fakulteit en dat u toestemming gee vir hierdie navorsings onderhoud vrywillig en dat u tydens hierdie onderhoud of tydens die navorsing is u enigetyd welkom as u voel u wil nie verder deel neem nie om te onttrek en dat dit geen nagevolge teen u as ‘n individu of teen die instansie sal hê nie. So as ons kan voortgaan dan sal ek bly wees

Deelnemer 2

Dit is reg

Veldwerker

Ek wil by u weet hoelank is u werksaam in hierdie noodeenheid?

Deelnemer 2

Uhmm 11 jaar en n paar maande

Veldwerker

Dit is n goeie tydjie en is dit net in die nood afdeling?

Deelnemer 2

Net in die noodeenheid,yes

Veldwerker

So, u het goeie ervaring in die noodverpleging en nood mediese deel. Kan u n insident onthou waar u dalk betrokke was tydens n resussitasie aangeleentheid waar die familie teenwoordig was?

Deelnemer 2

Ja, ons het so ‘n paar waar ons, waar die familie wel wil inkom as n mens dit vir hulle uhmm wil amper sê voorstel, partykeer wil hulle nie inkom nie maar ja daar is n paar waar hulle al by gestaan het.

Veldwerker

Kan u vir my bietjie meer uitbrei rondom hulle teenwooordigheid tydens n resussitasie?

Deelnemer 2

Uhmm, ons kry gewoonlik n dokter wat uitgaan om met die familie te gesels en vir hulle te vertel dat dinge lyk nie goed nie. Ons doen alles wat ons kan en of hulle wil sien of wat ons doen vir hulle familielid uhmm en daai spesifieke dokter kom dan saam met die persoon in as hulle dan so wil om te kom kyk en dan verduidelik daai spesifieke persoon terwyl die res van ons aangaan met die res van die resussitasie, uhmm wat besig is om te gebeur. So hulle sal bv, sê dat daai dokter is besig om op die borskas te druk om te kyk of ons die hart aan die gang kan kry en die bloed kan sirkuleer en daai een gebruik die masker met die sakkie om die suurstof in te kry, uhmm en daar is monitors gekoppel wat vir ons sê hoe vorder ons en bv die susters gee die medisyne om te kyk of ons half weer die hart kan “jumpstart” en aan die gang kan kry. Uhmm party keer vra hulle vrae maar baie min. Ek dink baie van hulle se wind is maar redelik uit hul seile uit as hulle daar staan, veral in ‘n trauma situasie waar hulle dit nie verwag het nie. Uhmm die wat al vir n langer tyd siek is, kan jy sien hulle het ‘n bietjie meer insig in die sin van hulle besef dat die familie lid is siek en….uhmm ja. So dit, jy kry die wat histeries aan die huil gaan en die wat letterlik net daar staan met hulle groot oe en kyk. Party wil daar staan totdat ons dit “call” en sê dit is klaar uhmm en uhmm dan is daar wel wat sê okay hulle het nou genoeg gesien hulle sal eerder buitekant gaan staan en ons kan dan vir hulle kom sê wat aangaan.

Veldwerker

As ek kan opsom dit klink asof daar baie voorligting gegee word en dat hierdie voorligting wat gegee word op ‘n vlak gegee word waar die familie dit kan verstaan.

Deelnemer 2

Ja. Ons probeer so plat as moontlik in Afrikaans en Engels praat, en nie ons mediese terme nie ja.

Veldwerker

En dat daar twee bene is rondom trauma en chroniese langtermyn pasiente en hoe families dit ervaar ook en hoe hulle tot berusting dan kom ook met die besluitneming en die proses van ‘n resussitasie.

Deelnemer 2

Ja Ja

Veldwerker

En dat u ook noem dat daar n spanbenadering moet wees rondom resussitasie en die hantering van die familie by die bed.

Deelnemer

Ja want baie keer veral die uhmm, as dit nou die ou tannie is wat van die huis af kom bv met die ambulans waar die ambulans klaar besig is met CPR uhmm, hou ons partykeer n bietjie langer aan vir die familie om te hoor of hulle wel wil kom kyk. Waar ons potensieel dit al kon “gecall” het en gesê het dit is klaar, wil ons net by die familie weet wil hulle kom kyk wat ons doen sodat hulle nie dink daar is niks gedoen vir hulle familielid nie. So indien hulle nou wel sê hulle wil glad nie kom kyk nie, want baie is uhmm het ‘n redelike sterk gevoel daaroor dat hulle wil nie sien nie, uhmm dan is dit “fine” want dan sê ons net okay dit is nou klaar, maar daar indien wel familie is wat wil kom kyk, wil amper sê, doen ons ‘n siklus of twee vir die familie. Ons weet dit is so half ‘n “futile” uitkoms ons gaan nie die pasient terug kry nie maar ons doen dit dan meer effektief meer vir die familie as vir die pasient self.

Veldwerker

So daar word eintlik na gekyk na die berusting van die familie

Deelnemer 2

Ons probeer so ver as moontlik ja.

Veldwerker

Om hulle te ondersteun in die proses. Hoe voel u oor die familie se teenwoordigheid as n dokter tydens ‘n resussitasie?

Deelnemer 2

Vir my, is dit glad nie ‘n issue as hulle daar staan nie, uhmm want jy wil, dit is ‘n gagga tyd in hulle lewe, uhmm “either way” verstaan of hulle daar staan of nie daar staan nie. So jy probeer, uhmm jy kan nie meer iets vir die persoon iets doen nie. Ons probeer dan so ver as moontlik iets vir die familie doen wat agter bly. So ek het persoonlik geen issue as hulle daar staan nie en as dit vir hulle gaan help om makliker deur hulle rou proses te gaan, by all means laat hulle daar staan. Uhmm ek dink as hulle daar gaan staan en niemand met hulle gaan praat en niemand vir hulle verduidelik nie , dan kan dit uhmm nie noodwendig half die beste ding wees nie want ek dink dit is in elk geval ‘n “ overwhelming” situasie vir hulle punt nommer 1 en nou kom jy in by monitors wat piep en ons wat soos ‘n gezoom bye daar met mekaar praat en te kere gaan. So uhmm, daar moet defnitief iemand wees. Uhmm ons probeer gewoonlik in die dag ‘n dokter kry om dit te doen maar partykeer as ons baie keer kort van hande is, kan ons wel een van die senior susters wat dalk nie noodwendig besig is met die resus nie om dalk vir ons met die pasient se familie te gaan praat en hulle dalk, daai praatwerk met hulle te doen. So dit hang alles af van wie,wie beskikbaar is, uhmm wat die situasie is want dit klink nou simple as daar ‘n hengse kar ongeluk is en daar is 3 of 4 kritiek siek pasiente gaan jy nie noodwendig n klomp dokters ‘n klomp en ekstra hande hê waar jy ‘n dokter kan kry om met hulle te gesels nie. So dan trek ons gewoonlik daar die verpleegpersoneel in om te gesels. Ek dink ons sal nooit vir hulle laat inkom en nie vir hulle verduidelik wat aangaan nie. So daar moet maar altyd iemand wees wat vir hulle kan verduidelik.

Veldwerker

U noem vir my dat die kommunikasie is n groot faktor tydens die resussitasie en dat die proses wat volg ook belangrik is, dat daar n “dedicated” span is, die kommunikasie moet deurgaan na die familie, die opsies word aan hulle bloot gestel en dat hulle ‘n keuse, ‘n ingeligte keuse kan maak van wil hulle teenwoordig by die bed wees of nie?

Deelnemer2

Absoluut ja.

Veldwerker

Kan ek vir u vra om bietjie meer uit te brei rondom trauma per se as die mediese ene weet ons dat die familie is bietjie meer ingelig, hulle sit dit half hier in hulle agterkop as ek so kan se. Maar in trauma is dit mos nou onvoorspelbaar en dat hierdie emosies is mos nou vars en hullle het dit nou nie beplan in hulle kop nie. Hoe voel u rondom trauma resussitasie met die familie by die bed as ons nou kan dink aan multi trauma gevalle?

Deelnemer 2

Kyk, uhmm meeste van die tyd wanneer ons die familie inroep, is dit wanneer ons so half besef ons gaan hierdie situasie nie verstaan, wen nie, dit gaan nie ‘n suksesvolle resussitasie wees nie. Uhmm so weereens, dan moet jy mooi gaan praat, jy moet mooi gaan. Gelukkig in daai opsig, uhmm jy stuur gewoonlik in die begin van die resus iemand uit om te gaan hoor wat is die geskeidenis, Is dit iemand wat allerhande ander siektes het en en en. Dat jy net weet half waarmee jy begin en dan gewoonlik sê ons vir hulle hoor gou dinge lyk nie goed nie. So jy probeer hulle in n mate ‘n bietjie voorberei op potensieel wat dalk kan kom. Ek dink nie dit half noodwendig in die sin van hoor gou dinge is nou regtig besig om suid te gaan nie, maar ek dink net dat jy half net so stadig kan voor berei dat dit nie net bv n fender bender of n klap in die gesig of whatever nie. Hierdie is baie baie ernstig. Uhmm ek het meer situasies gehad waar mense emosioneel hulself op die grond gegooi het en en en as hulle dit nie gesien het nie. As wat ons klaar is, ons hulle dan inroep en se hoor gou die ou het afgesterf. Uhmm as hulle kom kyk is dit half meer die persoon in hulle verstand lewe nog daar wat besig is om op te werk. Hulle sien hy lyk baie sleg en dit is nie dan daai wanneer die mense hulle fisies op die grond neer gou en hulle skree en gil en te kere gaan nie. Dan is hulle bietjie meer “composed”. En wanneer jy die nuus vir hulle gee, is dit ook nie in my opinie daai waar hulle hulself neergooi nie. Uhmm maar as jy hulle glad nie betrek het nie, en jy net vir hulle gaan sê dit is sleg, en jy het ook nie nie opsie gegee om te kom kyk nie, en jy gaan dan uit en se of roep hulle in (ons roep hulle gewoonlik in). Ons doen dit nou nie in die gang

nie. Hoor gou ons het alles gedoen , dan is hulle gewoonlik daai wat potensieel hulself op die grond kan neer gooi en gil en skree en so dat die hele eenheid weet dat iets is besig om te gebeur. So vir my in ‘n trauma situasie is dit amper half netso belangrik om hulle in te kry al dan, nie dalk bietjie meer nie omdat dit daai helse skok is want ek het n gesonde iemand werk toe gestuur en nou hoor ek hy is potensieel dood nie. So ek dink dit is “actually” wil amper sê half bietjie meer belangrik om hulle by te kry…uhmm sodat hulle kan sien wat besig is om te gebeur.

Veldwerker

So u noem vir my dat daar wel histerie is, dat die histerie aanvaarbaar is, as jy hulle tog wel betrek as wat jy hulle nie betrek nie en dit het sy voordeel in vir hulle om hulle self psigies voor te berei vir die pad wat vorentoe gaan lê en dat die profiel van die pasient ook tydens trauma ook belangrik is om vir julle insig te gee tydens die reussitasie waarmee julle eintlik te doen ongeag die trauma of die pasient chroniese faktore het wat tot sy nadeel kan tel nie

Deelnemer 2

Ja absoluut

Veldwerker

As so ‘n praktyk geimplementeer moet word dokter, hoe is die gevoel as ‘n mediese beampte oor dit?

Deelnemer 2

As dit so half ‘n moet gegaan word. Ek sal absoluut sê “go for it”. Ek is “happy” daarmee. Soos ek sê dit is baie selde dat mense gaan inroep as dit ‘n van die begin af n seep gladde maklike resus is en jy kry hulle binne 3 minute terug. Verstaan dan gaan jy nie mense inroep nie, dan stabiliseer jy jou pasient en jy roep dan die familie in wanneer alles aan die gang is. Jy hou hulle nogsteeds opdatum, maar ons gaan hulle nie noodwendig inroep nie. Maar as ‘n mens sien, verstaan jyt nou alles gedoen. Jy het nou vir 45 minute voluit gegaan en dit is bv nog steeds asistool of whatever die ritme is uhmm en jy sien daar is geen manier dat jy die wa deur die drif trek nie, dan is ek absoluut happy as hulle inkom. Uhmm want al wie ons kan help is die familie wat oor bly. Ons kan nie meer die pasient dan help nie

Veldwerker

So uit u oogpunt het dit sy voordeel en dit kan help vir die familie?

Deelnemer 2

Ja absoluut.

Veldwerker

Dan is daar n laaste vragie wat ek wil vra, was daar ooit ‘n situasie waar u tydens ‘n resussitasie was, waar dit dalk heeltemal hand uit geruk het waar dit gevoel het vir u hier moet ons nou ingryp want ons kan nie ons werk doen nie?

Deelnemer 2

Met die familie by? Nee glad nie. Ek weet nie of omdat dit ‘n skok is en ‘n vreemde situasie is en hulle net regtig waar “heartbroken” is oor wat hier voor hulle gebeur nie, maar die kere waar ons pasiente se familie ingekry het, was daar nog nooit histerie terwyl ons dit doen nie. Dalk het die regte gebroke snik huil uhmm waar jy kan sien hierdie is opreg ek is soos in besig om in my hart in 10000 stukkies te laat val, maar nog nooit histerie nie, nog nooit ‘n gegil of n geskree nie. Uhmm my ervaringe met familie wat dit by gewoon het was nog altyd positief. Ek het nog nooit ‘n negatiewe ervaring gehad nie.

Veldwerker

So as ons kan opsom is die kommunikasie ‘n groot en belangriker faktor (Jy moet hulle voorberei oor wat hulle gaan sien- deelnemer 2) tydens resussitasie en die wyse waar ons hierdie boodskap ook oordra vir die familie (Deelnemer – Ja absoluut). En dat dit eintlik tot voordeel het om ‘n pasient te resussiteer met die familie in die praktyk

Deelnemer 2

Ek dink absoluut so. Uhmm dit is baie waar wat jy se, kommunikasie. Jy kan hulle nie daar laat inkom en jy het nie vir hulle voorberei dat daar is ‘n klomp pype, ‘n klomp dokters en ‘n klomp goeters wat gaan gebeur nie. Dit kan partykeer n redelike besige aktiewe woeste situasie wees daar en as jy nie vir die familie verduidelik punt

nommer een, dit is hoe dit gaan lyk nie en wat elkeen doen nie. Sal nie se dit is useless nie , kan jy potensieel dalk n bietjie nie skade maak nie maar jy kan dalk vir hulle vir verwerking vir na die tyd erger maak as wat jy vir hulle voor die tyd sê jy gaan a b c en d sien en dit is wat a b c en d doen. Sodat hulle sal vrede hê met dit wat met hulle familie lid gebeur.

Veldwerker

So basies is dit die persoon wat daai boodskap oordra is goud (deelnemer- absoluut) daai persoon moet weet, hy moet kennis hê, hy moet empatie kan hê, hy moet weet hoe om die boodskap te kan oordra in n verstaanbare manier.

Deelnemer 2

Dit help nie jy gaan se vir mense hier word CPR gedoen en daai is n ventilator en dit is n bloedgas en dit daai is dit nie. Jy moet die taal praat wat mense kan verstaan.

Veldwerker

Baie baie dankie dokter vir u tyd en u deelname in hierdie navorsing en mooi dag vir u hoor..

Deelnemer

Groor plesier en dankie.

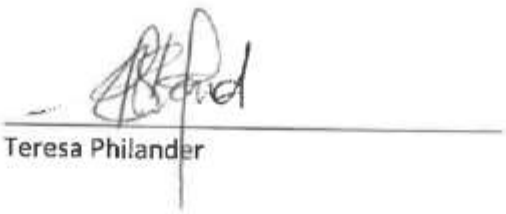
Appendix 8: Declarations by language and technical editors

DECLARATION BY EDITOR

24 February 2020

RE: Language editing of thesis

This is to confirm that I, Teresa Philander, edited the master's thesis of Ms Hanilene Russel titled "Exploring the perceptions of medical officers and nursing professionals about family presence during cardiopulmonary resuscitation". I edited the language, grammar and punctuation of this document to the best of my ability.



Teresa Philander